HOSPITAL AFFILIATION INFORMATION

Name of Training Program: ____

EMS Training Program Level: ❑ EMT ❑ AEMT ❑ EMT-P ❑ MICN ❑ Other: ________

Complete the following information for each ambulance service and/or field provider utilized by your training program for the supervised clinical instruction of your EMS students. Include a copy of the written agreement between your institution and each agency with this form.

1. Name: ____

   Address: ____

   ____

   Contact Person: ____________________________________ Title: ____________________

   Telephone: ( ) ____________________________ Ext: __________________

   Patient Care Areas Utilized:

   - ☐ Emergency Dept.
   - ☐ Intensive Care
   - ☐ Burn Ward
   - ☐ Labor and Delivery
   - ☐ Operating Room
   - ☐ Other ____________________________

2. Name: ____

   Address: ____

   ____

   Contact Person: ____________________________________ Title: ____________________

   Telephone: ( ) ____________________________ Ext: __________________

   Patient Care Areas Utilized:

   - ☐ Emergency Dept.
   - ☐ Intensive Care
   - ☐ Burn Ward
   - ☐ Labor and Delivery
   - ☐ Operating Room
   - ☐ Other ____________________________

County of Riverside, Emergency Management Department, EMERGENCY MEDICAL SERVICES AGENCY
4210 Riverwalk Parkway, Suite 300, Riverside, California 92505
Phone: (951) 358-5029 Fax: (951) 358-5160
Form revision 5/17mp

HOSPITAL AFFILIATION INFORMATION

3. Name: ____

Address: ____

____

Contact Person: ________________________________ Title: __________________

Telephone: (   ) _________________________ Ext: ______________

Patient Care Areas Utilized:

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