HOSPITAL AFFLIATION INFORMATION FORM

Training Center Name:	
Address:	
EMS Training Prog. Level:	Please select one: If Other: ______________________________

Complete the following information for each hospital provider utilized by your training program for the supervised clinical instruction of your EMS students. Please include a copy of the written agreement between your institution and each agency with this form.						
1. Name of Hospital:						
Address:						
Contact Person Name:						
Contact Person Title:						
Contact Person Phone:						
Patient Care Area Utilized:	☐ **E.R.**	☐ **I.C.U.**	☐ **Burn Unit**	☐ **L & D**	☐ **O.R.**	☐ **Other**
	Other: ____					
2. Name of Hospital:						
Address:						
Contact Person Name:						
Contact Person Title:						
Contact Person Phone:						
Patient Care Area Utilized:	☐ **E.R.**	☐ **I.C.U.**	☐ **Burn Unit**	☐ **L & D**	☐ **O.R.**	
	Other: ____					
3. Name of Hospital:						
Address:						
Contact Person Name:						
Contact Person Title:						
Contact Person Phone:						
Patient Care Area Utilized:	☐ **E.R.**	☐ **I.C.U.**	☐ **Burn Unit**	☐ **L & D**	☐ **O.R.**	
	Other: ____					

INSTRUCTIONS:

Please email the completed form to emstraining@rivco.org Once this form has been received, EMS Agency staff will review and communicate back the status.