

REGION 7 EMS
ECRN COURSE APPLICATION / SYSTEM ENTRY APPLICATION
FOR COURSE CANDIDATES & SYSTEM ENTRY

Check One: [] Registering for _____ (date) ECRN Course.
[] Licensed ECRN entering the System.

DATE: ___/___/___ LAST NAME: _____ FIRST NAME: _____

HOME ADDRESS: _____ CITY: _____ ST: ___ ZIP: _____

CELL PHONE: (____) _____ - _____ R.N. LICENSE #: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: ___/___/___

E-MAIL (PRINT LEGIBLY): _____

HOSPITAL WHERE YOU WORK Circle One: Silver Cross or Saint Joes

EMS SYSTEM: Silver Cross EMS System

CIRCLE ANY THAT APPLY

ECRN EMT EMT-I PARAMEDIC PHRN > & include IDPH License# _____

IF ALREADY LICENSED AS AN ECRN: GIVE DATE OF ORIGINAL ECRN COURSE: ___/___/___ and what Region: _____

CHECK AND COMPLETE ANY THAT APPLY

TNS ___ Expiration Date: ___/___/___ IDPH License # _____

TNCC ___ Expiration Date: ___/___/___ PHTLS ___ Expiration date: ___/___/___

ACLS ___ Expiration date: ___/___/___ PALS ___ Expiration date: ___/___/___

ATTACH CLEAR/LEGIBLE COPIES OF LICENSES AND CARDS. SEND COMPLETED APPLICATION TO YOUR HOSPITAL'S EMS COORDINATOR, WHO WILL SUBMIT TO THE SYSTEM RESOURCE HOSPITAL FOR PROCESSING.

*Candidate's ER manager must sign for approval as well as System Resource Hospital EMS Coordinator.

ER Manager or designee Signature/Approval

Silver Cross EMS Coordinator or designee Signature/Approval