



O'Fallon Emergency Medical Services

O'Fallon Public Safety Facility: 285 North Seven Hills Road: O'Fallon, IL 62269
Phone: (618) 624-4545 Ext 5, Fax (618) 624-8138

Application for Ride-Along Program (Return Completed Forms to EMS Department)

Personal Information

Name: (First, Middle, Last) _____

Home Address: _____ City _____ State _____

Home Phone: (____) ____-____ Cell Phone: (____) ____-____

E-Mail Address: _____

Driver's License Information

License Number: _____ State of Issue: _____

License Class: _____ Date of Issue: ____/____/____

Expires: ____/____/____ Date of Birth: ____/____/____

Please attach a copy of your current driver's license

Certifications

Check all that apply:

- ☐ CPR Issuer _____ Expires: ____/____
- ☐ First Aid Issuer _____ Expires: ____/____
- ☐ First Res. State _____ Number _____ Expires: ____/____
- ☐ EMT-B State _____ Number _____ Expires: ____/____
- ☐ EMT-I State _____ Number _____ Expires: ____/____
- ☐ EMT-P State _____ Number _____ Expires: ____/____
- ☐ ACLS Issuer _____ Expires: ____/____
- ☐ ITLS Issuer _____ Expires: ____/____
- ☐ PALS Issuer _____ Expires: ____/____

Experience

If you have been employed by or volunteered on an ambulance or in a medical environment, please specify below:

Organization: _____

Name of Supervisor: _____ Phone (____) ____ - _____

Describe work done:

Certification

I certify that this information given on this application is true and correct to the best of my knowledge, and that false statements on this application may be sufficient grounds for termination of participation in the ride-along program. I also knowingly and willingly permit the O'Fallon Public Safety Department to investigate any and all of the information that I have submitted and agree to allow the O'Fallon Public Safety Department to complete a full background check.

Signed: _____ Date: ____/____/____

Protected Health Information

During a ride-along, participants may come into contact with private health-related information. The Health Insurance Portability and Accountability Act (HIPAA) mandates that all confidential information learned during the ride-along remain confidential.

☐ By checking this box, I agree and understand the HIPPA requirements listed above and will not share any personal information that I may be exposed to during my ride-along.

***OFFICE USE ONLY**

Approved By: _____

Date: ____/____/____