



# McLean County Area EMS System

112 A Southgate Drive  
Bloomington, IL 61704

Phone: (309) 827-4348  
Fax: (309) 827-2017

## Emergency Communications Registered Nurse (ECRN)

Course Date: \_\_\_\_\_

Name \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
(if available)

Cell Phone \_\_\_\_\_ (E-mail (optional)) \_\_\_\_\_  
(if available)

Sponsoring Hospital \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

### EMS Office Use Only

	Completed	Exp. Date	Copy on File	Date Received
Prerequisites - RN	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
ACLS	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Trauma Course	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
CPR	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____

### Skill Validation & Testing

Written Examination - Date \_\_\_\_\_ Score \_\_\_\_\_

Re-test Date \_\_\_\_\_ Score \_\_\_\_\_

ECRN Quiz- Date \_\_\_\_\_ Score \_\_\_\_\_

Re-test Date \_\_\_\_\_ Score \_\_\_\_\_

Radio Report Scenario -

Date \_\_\_\_\_ Given By \_\_\_\_\_ Pass Fail

Re-Test Date \_\_\_\_\_ Given By \_\_\_\_\_ Pass Fail

### Field Experience/Clinical

Clinical Observation Time on ALS Unit -

Date \_\_\_\_\_ # Calls \_\_\_\_\_ # Hours \_\_\_\_\_ Preceptor \_\_\_\_\_

Date \_\_\_\_\_ # Calls \_\_\_\_\_ # Hours \_\_\_\_\_ Preceptor \_\_\_\_\_

### State License

Transaction Card Submitted by \_\_\_\_\_ Date \_\_\_\_\_

Attach copy of License when received

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