



**RIDE ALONG REQUEST FORM**

Fax Form: 902-892-9993

Information: 902-892-9995

Mail Form: Island EMS  
229 Sherwood Rd.  
Charlottetown, P.E.I  
C1E 0E5

<b>For Office Use Only</b>		
<b>Supervisor:</b> _____		
<b>Base:</b> _____	<b>Fax:</b> _____	

*Before you begin! Please print clearly and complete all sections of this form. Illegible and/or incomplete forms will not be processed. Your application will be considered based on the Ride Along Program Policy. You will receive notification whether you are declined or accepted into the Ride Along Program. **A Ride Along Statement must accompany this form.***

Date of Application: \_\_\_\_\_ Date of Birth (19 yr. minimum): \_\_\_\_\_

Full Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Contact Number(s): Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cellular: \_\_\_\_\_

Requested Paramedic Base: 1<sup>st</sup> Choice \_\_\_\_\_ 2<sup>nd</sup> Choice \_\_\_\_\_

Date(s) Requested (Allow at least 2 weeks for processing): \_\_\_\_\_

Employer/School: \_\_\_\_\_

Profession: Paramedic \_\_\_\_\_ RN \_\_\_\_\_ Fire \_\_\_\_\_ Police \_\_\_\_\_ Other \_\_\_\_\_

If Other, please specify: \_\_\_\_\_

Please describe the purpose for your ride along:  
\_\_\_\_\_

Insurance Info: Y /N \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature Of Applicant**                      **Date of Application**

<b>For Office Use Only</b>	
<b>Approved:</b> _____	
<b>Declined:</b> _____	
<b>Coordinator:</b> _____	
<b>Contacted:</b> _____	
<b>Supervisor:</b> _____	



**RIDE ALONG STATEMENT**

***Before You Begin! This form must accompany all Ride Along Request Forms. It does not guarantee approval to participate in the Island EMS Ride Along Program***

**Please print your full name here**

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I have requested permission to ride along as a guest or observer in an Island EMS system vehicle for the following date(s)\_\_\_\_\_ (date(s) on request form).

I agree to follow the directions given to me by the members of the ambulance crew, Island EMS and the ground ambulance contractor at all times.

I understand that patient information and the records of the Island EMS system are confidential, and I agree to preserve that confidentiality.

I understand that I am not permitted to drive any Island EMS vehicle under any circumstance.

I release Island EMS, Health P.E.I., the Island EMS Medical Director and/or Medical Control Physicians, and all of their individual members or employees from all actions, claims or demands arising from any personal loss, injury, or death resulting from this ride along, no matter how they are caused.

I indemnify the above for any loss or damages which I may cause during the course of this ride along.

\_\_\_\_\_  
**Signature of Ride Along**

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness Name (Please print)**

\_\_\_\_\_  
**Witness Paramedic ID Number**