SACRAMENTO COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF EMERGENCY MEDICAL SERVICES
EMT-I TRAINING PROGRAM

4. HOSPITAL/AMBULANCE AFFILIATION FORM

1. Name(s) of hospital(s) where student emergency department instruction located. Note that a copy of the written agreements with the hospital must be attached.	
A.	Name:
	Address:
	Clinical Supervisor:
	Phone:
B.	Name:
	Address:
	Clinical Supervisor:
	Phone:
2. Name(s) of ambulance service(s) where student observation on an operational emergency ambulance is located. Note that a copy of the written agreements must be attached.	
A.	Name:
	Address:
	Contact Person:
	Phone:
B.	Name:
	Address:
	Contact Person:
	Phone:
Date form completed:	