SACRAMENTO COUNTY EMS AGENCY
MOBILE INTENSIVE CARE NURSE
RIDE-ALONG FOR

(*All required information must be filled out or it will be marked incomplete)

*MICN NAME:	*ALS PROVIDER: *UNIT #:
*DATE:	*TOTAL HOURS:

URGENCY/TYPE OF CALL/PATIENT PROFILE:	COMMENTS:
*1.	
*2.	
3.	
4.	
5.	
6.	
COMMENTS:	

*EMT-P PRINTED NAME: _____ *EMT-P SIGNATURE: _____

*LICENSE NUMBER: _____ *DATE: _____

MICN INITIAL: DOCUMENTATION OF EIGHT (8) HOURS OF DIRECT OBSERVATION, WHICH MUST INCLUDE TWO (2) PATIENT CONTACTS. IF TWO (2) PATIENT CANTACTS ARE NOT COMPLETED, TWO (2) ALS SCENARIOS WILL BE CONDUCTED BY THE PARAMEDIC WITHIN THE EIGHT (8) HOUR OBSERVATION PERIOD.

MICN RENEWAL: DOCUMENTATION OF FOUR (4) HOURS OF DIRECT OBSERVATION, WHICH MUST INCLUDE TWO (2) PATIENT CONTACTS. IF TWO (2) PATIENT CANTACTS ARE NOT COMPLETED, TWO (2) ALS SCENARIOS WILL BE CONDUCTED BY THE PARAMEDIC WITHIN THE FOUR (4) HOUR OBSERVATION PERIOD.