

EMS Internship Documentation Form

Name: _____

Address: _____

Social Security Number _____

Location: _____

EMT-B EMT-I EMT-P

Use separate form for Ambulance and Hospital Internship

Clinical Site or Ambulance Internship Site

A. _____

B. _____

C. _____

School Number: _____

Coordinator: _____

Clinical Area/Site	Date	Time In	Time Out	Number Of Hours	Description of Patient Management	Staff Signature

Total Hours This Sheet: _____ Total Hours All Sheets: _____ Coordinator's Signature: _____