



SACRAMENTO COUNTY EMS AGENCY
MOBILE INTENSIVE CARE NURSE
RIDE-ALONG FORM
(TO BE COMPLETED BY MICN)

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|--------------------------------------|--------------|
| MICN (NAME): | AGENCY: |
| EMT-P (NAME): | UNIT #: |
| DATE: _____ TIME: FROM TO | TOTAL HOURS: |

| URGENCY/TYPE OF CALL/PATIENT PROFILE | COMMENTS |
|--------------------------------------|----------|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |

| |
|-------------------|
| OVERALL COMMENTS: |
|-------------------|

| | |
|------------------------|-------------|
| EMT-P SIGNATURE: _____ | DATE: _____ |
| CERTIFICATION #: _____ | |