Maryland Fire & Rescue Institute

Emergency Medical Technician Course – EMS 106

MFRI Student / Field Training Coach Internship Agreement

This agreement must be signed and turned in to the instructor prior to the student beginning EMT Module 3.

The field internship is the process of training outside of the classroom under the guidance of an approved company, department, or jurisdictional approved Field Training Coach. An emergency medical technician field training coach shall possess appropriate:

(a) Working knowledge of the emergency medical technician curriculum;

(b) Working knowledge of the Maryland Medical Protocols for Emergency Medical Services Providers; and

(c) Expertise to supervise students during the emergency medical technician internship.

(3) The ratio of students to emergency medical technician field training coach shall be one to one to ensure effective learning and supervision.

(4) Each emergency medical technician field training coach shall complete emergency medical technician field training coach orientation, and be approved by the local EMS operational program

The field internship will place the student in "the field," or real world, meaning the student will receive practical experience before practicing on their own.

You will be required to complete the Field Internship Packet, which is a compilation of MIEMSS approved forms, and will document your field experience. This may not commence prior to successful completion of EMT Module Two – Assessment.

You will in conjunction with a jurisdiction approved field training coach arrange site visits. The Field Internship is separate from the 165 hours of MFRI course work, and is required by MIEMSS for certification.

Your internship must consist of the following two sections;

I. Ten patient assessments in the presence of the field training coach. Refusals of service do not count towards the ten assessments
II. An orientation consisting of five hours, including of the following;
    a. A full ambulance orientation & inspection – you may visit the location where the ambulance is stationed, or the ambulance may be brought to the class site. This must take a minimum of one hour.
    b. Tour of a Communications / 911 Center – this must take a minimum of two hours.
    c. Tour of a Med Evac helicopter. This must take a minimum of two hours.

You must submit the completed paperwork to the instructor before you can take the written and practical certification tests. The instructor will check the packet and sign it off, the internship packet will then be turned in to MIEMSS.

By my signature I hereby:

1. Understand that all of the above information I have given is subject to verification.
2. Affirm and declare that all of the above information I provided is true and correct to the best of my knowledge.
3. Acknowledge that any fraudulent entry may be considered sufficient cause for rejection or subsequent revocation.

Student printed name: _____

Student signature: _____

Field Training Coach printed name: _____

Field Training Coach signature: _____

Approved by Local EMS Operational Program

EMS Operational Program printed name _____

EMS Operational Program signature _____

EMT Internship

Name: ______________________________
PLEASE PRINT

SSN: ____________________ Course No.: ____________

Patient Assessments (minimum 10 satisfactory)

☐ **Patient** ______ / ______ (MAIS NO. / FTC INITIALS) ☐ **Patient** ______ / ______ (MAIS NO. / FTC INITIALS)

☐ **Patient** ______ / ______ (MAIS NO. / FTC INITIALS) ☐ **Patient** ______ / ______ (MAIS NO. / FTC INITIALS)

☐ **Patient** ______ / ______ (MAIS NO. / FTC INITIALS) ☐ **Patient** ______ / ______ (MAIS NO. / FTC INITIALS)

☐ **Patient** ______ / ______ (MAIS NO. / FTC INITIALS) ☐ **Patient** ______ / ______ (MAIS NO. / FTC INITIALS)

☐ **Patient** ______ / ______ (MAIS NO. / FTC INITIALS) ☐ **Patient** ______ / ______ (MAIS NO. / FTC INITIALS)

Orientation (minimum 5 hours)

☐ **Ambulance/BLS** (1 hour) ______________________________

☐ **EMS Communication** (2 hour) ______________________________

Options:

☐ ______________________________

☐ ______________________________

☐ ______________________________

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2. AFFIRM AND DECLARE THAT ALL OF THE ABOVE INFORMATION I PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.
3. ACKNOWLEDGE THAT ANY FRAUDULENT ENTRY MAY BE CONSIDERED SUFFICIENT CAUSE FOR REJECTION OR SUBSEQUENT REVOCATION.

Student Signature: ______________________ Date: __________

THE STUDENT HAS SUCCESSFULLY COMPLETED THE EMT-B INTERNSHIP.

Instructor: *PLEASE PRINT* ______________________

Signature ______________________ Date: __________

6/96

EMT-B Internship
ORIENTATION ROTATIONS

Name: _____
PLEASE PRINT

SSN: _____ Course No.: _____

☐ **Ambulance/BLS** ☐ Satisfactory

List Activities: _____

Field Training Coach: _____ Date: _____

☐ **EMS Communication** ☐ Satisfactory

List Activities: _____

Field Training Coach: _____ Date: _____

OPTIONS

☐ _____ ☐ Satisfactory

List Activities: _____

Field Training Coach: _____ Date: _____

☐ _____ ☐ Satisfactory

List Activities: _____

Field Training Coach: _____ Date: _____

☐ _____ ☐ Satisfactory

List Activities: _____

Field Training Coach: _____ Date: _____

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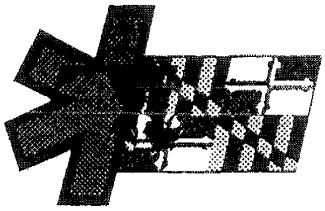
Student Signature: _____ Date: _____

7/95



EMT Internship
PATIENT ASSESSMENTS

Name: _____
PLEASE PRINT

SSN: _____ Course No.:_____

The EMT students must assess and record assessments and care rendered on the ambulance runsheet (other side) for each patient:

- **Vital signs**
- **History**
- **Assessment**
- **Documentation of time**
- **Treatment provided**
- **Transport/communication**

NOTE: The student must complete a minimum of 5 satisfactory patient assessments

Patient _____

☐ Satisfactory
☐ Needs Remedial Practice Date:_____
☐ Satisfactory Remedial Date:_____

Comments:_____

_____

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Student Signature: _____ Date_____

Field Training Coach: _____
PLEASE PRINT

Signature:_____ Date:_____

Maryland Institute For
Emergency Medical Services Systems

Patient Information Sheet

Incident # _____ **Date:** _____ **Time:** _____ **Arrived at Hospital:** _____ **Age:** _____ **Unit #:** _____

Gender: ❑M ❑F **Wt:** _____ Kg/Lbs **Trauma Category:** ❑A ❑B ❑C ❑D **Priority:** ❑1 ❑2 ❑3 ❑4 **Level of Consciousness:** ❑A ❑V ❑P ❑U

Patient Name: _____ **Date of Birth** _____ **Patient's Address:** _____

City: _____ **State:** _____ **Patient's Phone Number ( )** _____

Chief Complaint: _____

Past Medical History (DNR ❑ A1 ❑ A2 (DNI) ❑ B): _____

Current Medications: _____

Allergies: _____

Initial Vitals:	**Repeat Vitals:**	**Skin**	**Neurology**	**Cardiac Rhythm:**	**Oxygen**	**Respiratory**	**Pulse**
B/P: ____/____	**B/P:** ____/____	❑ Warm	❑ Alert	_____	❑ NR Mask	❑ Clear	❑ Regular
Pulse: _____	**Pulse:** _____	❑ Hot	❑ Verbal	**Glucometer:**	❑ Nasal Cannula	❑ Rales	❑ Irregular
Respirations: ____	**Respirations:** ____	❑ Cool	❑ Pain	_____	____ L/min.	❑ Labored	❑ Thready
SAO2: _____%	**SAO2:** _____%	❑ Dry	❑ Unconscious	**SAO2:** _____%	❑ BVM	❑ Stridor	Circulation
		❑ Clammy	**Pupils:**	❑IV1 ❑IV2	❑ ET ❑ NT	❑ Rhonchi	❑ JVD
		❑ Diaphoretic	❑ PERRL	❑IO ❑EJ	❑ Combitube	❑ Wheezes	❑ Edema Cap. Refill:
		❑ Cyanotic	❑ Unequal	Rate: _____	❑ CPR in Progress	❑ Decreased	____ sec.
			❑ Fixed and Dilated	Gauge: _____	❑ Ventilator	❑L ❑R	
				Site: _____	❑ NGT		
				Amount Infused: _____			
				❑ Bloods Drawn			

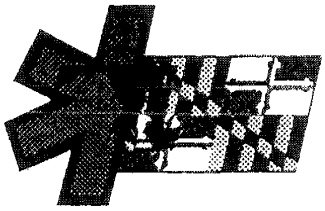
Assessment/Treatment: _____

_____

_____

Provider's Signature: _____ **Date:** _____ **Hospital Signature:** _____

Version 1/12



EMT Internship
PATIENT ASSESSMENTS

Name: _____
PLEASE PRINT

SSN: _____ Course No.:_____

The EMT students must assess and record assessments and care rendered on the ambulance runsheet (other side) for each patient:

- **Vital signs**
- **History**
- **Assessment**
- **Documentation of time**
- **Treatment provided**
- **Transport/communication**

NOTE: The student must complete a minimum of 5 satisfactory patient assessments

Patient _____

☐ Satisfactory
☐ Needs Remedial Practice Date:_____
☐ Satisfactory Remedial Date:_____

Comments:_____

_____

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Student Signature: _____ Date_____

Field Training Coach: _____
PLEASE PRINT

Signature:_____ Date:_____

Maryland Institute For
Emergency Medical Services Systems

Patient Information Sheet

Incident # _____ **Date:** _____ **Time:** _____ **Arrived at Hospital:** _____ **Age:** _____ **Unit #:** _____

Gender: ❑M ❑F **Wt:** _____ Kg/Lbs **Trauma Category:** ❑A ❑B ❑C ❑D **Priority:** ❑1 ❑2 ❑3 ❑4 **Level of Consciousness:** ❑A ❑V ❑P ❑U

Patient Name: _____ **Date of Birth** _____ **Patient's Address:** _____

City: _____ **State:** _____ **Patient's Phone Number ( )** _____

Chief Complaint: _____

Past Medical History (DNR ❑ A1 ❑ A2 (DNI) ❑ B): _____

Current Medications: _____

Allergies: _____

Initial Vitals:	**Repeat Vitals:**	**Skin**	**Neurology**	**Cardiac Rhythm:**	**Oxygen**	**Respiratory**	**Pulse**
B/P: ____/____	**B/P:** ____/____	❑ Warm	❑ Alert	_____	❑ NR Mask	❑ Clear	❑ Regular
Pulse: _____	**Pulse:** _____	❑ Hot	❑ Verbal	**Glucometer:**	❑ Nasal Cannula	❑ Rales	❑ Irregular
Respirations: ____	**Respirations:** ____	❑ Cool	❑ Pain	_____	____ L/min.	❑ Labored	❑ Thready
SAO2: _____%	**SAO2:** _____%	❑ Dry	❑ Unconscious	**SAO2:** _____%	❑ BVM	❑ Stridor	Circulation
		❑ Clammy	**Pupils:**	❑IV1 ❑IV2	❑ ET ❑ NT	❑ Rhonchi	❑ JVD
		❑ Diaphoretic	❑ PERRL	❑IO ❑EJ	❑ Combitube	❑ Wheezes	❑ Edema Cap. Refill:
		❑ Cyanotic	❑ Unequal	Rate: _____	❑ CPR in Progress	❑ Decreased	____ sec.
			❑ Fixed and Dilated	Gauge: _____	❑ Ventilator	❑L ❑R	
				Site: _____	❑ NGT		
				Amount Infused: _____			
				❑ Bloods Drawn			

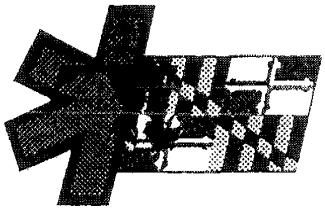
Assessment/Treatment: _____

_____

_____

Provider's Signature: _____ **Date:** _____ **Hospital Signature:** _____

Version 1/12



EMT Internship
PATIENT ASSESSMENTS

Name: _____
PLEASE PRINT

SSN: _____ Course No.:_____

The EMT students must assess and record assessments and care rendered on the ambulance runsheet (other side) for each patient:

- **Vital signs**
- **History**
- **Assessment**
- **Documentation of time**
- **Treatment provided**
- **Transport/communication**

NOTE: The student must complete a minimum of 5 satisfactory patient assessments

Patient _____

☐ Satisfactory
☐ Needs Remedial Practice Date:_____
☐ Satisfactory Remedial Date:_____

Comments:_____

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Student Signature: _____ Date_____

Field Training Coach: _____
PLEASE PRINT

Signature:_____ Date:_____

Maryland Institute For
Emergency Medical Services Systems

Patient Information Sheet

Incident # _____ **Date:** _____ **Time:** _____ **Arrived at Hospital:** _____ **Age:** _____ **Unit #:** _____

Gender: ❑M ❑F **Wt:** _____ Kg/Lbs **Trauma Category:** ❑A ❑B ❑C ❑D **Priority:** ❑1 ❑2 ❑3 ❑4 **Level of Consciousness:** ❑A ❑V ❑P ❑U

Patient Name: _____ **Date of Birth** _____ **Patient's Address:** _____

City: _____ **State:** _____ **Patient's Phone Number ( )** _____

Chief Complaint: _____

Past Medical History (DNR ❑ A1 ❑ A2 (DNI) ❑ B): _____

Current Medications: _____

Allergies: _____

Initial Vitals:	**Repeat Vitals:**	**Skin**	**Neurology**	**Cardiac Rhythm:**	**Oxygen**	**Respiratory**	**Pulse**
B/P: ____/____	**B/P:** ____/____	❑ Warm	❑ Alert	_____	❑ NR Mask	❑ Clear	❑ Regular
Pulse: _____	**Pulse:** _____	❑ Hot	❑ Verbal	**Glucometer:**	❑ Nasal Cannula	❑ Rales	❑ Irregular
Respirations: ____	**Respirations:** ____	❑ Cool	❑ Pain	_____	____ L/min.	❑ Labored	❑ Thready
SAO2: _____%	**SAO2:** _____%	❑ Dry	❑ Unconscious	**SAO2:** _____%	❑ BVM	❑ Stridor	Circulation
		❑ Clammy	**Pupils:**	❑IV1 ❑IV2	❑ ET ❑ NT	❑ Rhonchi	❑ JVD
		❑ Diaphoretic	❑ PERRL	❑IO ❑EJ	❑ Combitube	❑ Wheezes	❑ Edema Cap. Refill:
		❑ Cyanotic	❑ Unequal	Rate: _____	❑ CPR in Progress	❑ Decreased	____ sec.
			❑ Fixed and Dilated	Gauge: _____	❑ Ventilator	❑L ❑R	
				Site: _____	❑ NGT		
				Amount Infused: _____			
				❑ Bloods Drawn			

Assessment/Treatment: _____

_____

_____

Provider's Signature: _____ **Date:** _____ **Hospital Signature:** _____

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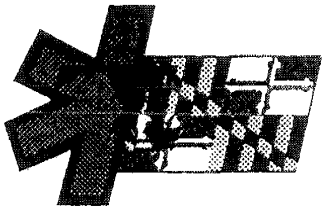

EMT Internship
PATIENT ASSESSMENTS

Name: _____
PLEASE PRINT

SSN: _____ Course No.:_____

The EMT students must assess and record assessments and care rendered on the ambulance runsheet (other side) for each patient:

- **Vital signs**
- **History**
- **Assessment**
- **Documentation of time**
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Patient _____

☐ Satisfactory
☐ Needs Remedial Practice Date:_____
☐ Satisfactory Remedial Date:_____

Comments:_____

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Student Signature: _____ Date_____

Field Training Coach: _____
PLEASE PRINT

Signature:_____ Date:_____

Maryland Institute For
Emergency Medical Services Systems

Patient Information Sheet

Incident # _____ **Date:** _____ **Time:** _____ **Arrived at Hospital:** _____ **Age:** _____ **Unit #:** _____

Gender: ❑M ❑F **Wt:** _____ Kg/Lbs **Trauma Category:** ❑A ❑B ❑C ❑D **Priority:** ❑1 ❑2 ❑3 ❑4 **Level of Consciousness:** ❑A ❑V ❑P ❑U

Patient Name: _____ **Date of Birth** _____ **Patient's Address:** _____

City: _____ **State:** _____ **Patient's Phone Number ( )** _____

Chief Complaint: _____

Past Medical History (DNR ❑ A1 ❑ A2 (DNI) ❑ B): _____

Current Medications: _____

Allergies: _____

Initial Vitals:	**Repeat Vitals:**	**Skin**	**Neurology**	**Cardiac Rhythm:**	**Oxygen**	**Respiratory**	**Pulse**
B/P: ____/____	**B/P:** ____/____	❑ Warm	❑ Alert	_____	❑ NR Mask	❑ Clear	❑ Regular
Pulse: _____	**Pulse:** _____	❑ Hot	❑ Verbal	**Glucometer:**	❑ Nasal Cannula	❑ Rales	❑ Irregular
Respirations: ____	**Respirations:** ____	❑ Cool	❑ Pain	_____	____ L/min.	❑ Labored	❑ Thready
SAO2: _____%	**SAO2:** _____%	❑ Dry	❑ Unconscious	**SAO2:** _____%	❑ BVM	❑ Stridor	Circulation
		❑ Clammy	**Pupils:**	❑IV1 ❑IV2	❑ ET ❑ NT	❑ Rhonchi	❑ JVD
		❑ Diaphoretic	❑ PERRL	❑IO ❑EJ	❑ Combitube	❑ Wheezes	❑ Edema Cap. Refill:
		❑ Cyanotic	❑ Unequal	Rate: _____	❑ CPR in Progress	❑ Decreased	____ sec.
			❑ Fixed and Dilated	Gauge: _____	❑ Ventilator	❑L ❑R	
				Site: _____	❑ NGT		
				Amount Infused: _____			
				❑ Bloods Drawn			

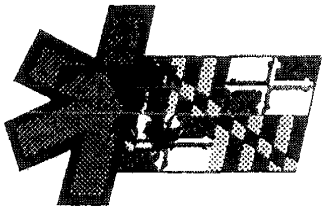
Assessment/Treatment: _____

_____

_____

Provider's Signature: _____ **Date:** _____ **Hospital Signature:** _____

Version 1/12



EMT Internship
PATIENT ASSESSMENTS

Name: _____
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Patient _____

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☐ Satisfactory Remedial Date:_____

Comments:_____

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Student Signature: _____ Date_____

Field Training Coach: _____
PLEASE PRINT

Signature:_____ Date:_____

Maryland Institute For
Emergency Medical Services Systems

Patient Information Sheet

Incident # _____ **Date:** _____ **Time:** _____ **Arrived at Hospital:** _____ **Age:** _____ **Unit #:** _____

Gender: ❑M ❑F **Wt:** _____ Kg/Lbs **Trauma Category:** ❑A ❑B ❑C ❑D **Priority:** ❑1 ❑2 ❑3 ❑4 **Level of Consciousness:** ❑A ❑V ❑P ❑U

Patient Name: _____ **Date of Birth** _____ **Patient's Address:** _____

City: _____ **State:** _____ **Patient's Phone Number ( )** _____

Chief Complaint: _____

Past Medical History (DNR ❑ A1 ❑ A2 (DNI) ❑ B): _____

Current Medications: _____

Allergies: _____

Initial Vitals:	**Repeat Vitals:**	**Skin**	**Neurology**	**Cardiac Rhythm:**	**Oxygen**	**Respiratory**	**Pulse**
B/P: ____/____	**B/P:** ____/____	❑ Warm	❑ Alert	_____	❑ NR Mask	❑ Clear	❑ Regular
Pulse: _____	**Pulse:** _____	❑ Hot	❑ Verbal	**Glucometer:**	❑ Nasal Cannula	❑ Rales	❑ Irregular
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		❑ Clammy	**Pupils:**	❑IV1 ❑IV2	❑ ET ❑ NT	❑ Rhonchi	❑ JVD
		❑ Diaphoretic	❑ PERRL	❑IO ❑EJ	❑ Combitube	❑ Wheezes	❑ Edema Cap. Refill:
		❑ Cyanotic	❑ Unequal	Rate: _____	❑ CPR in Progress	❑ Decreased	____ sec.
			❑ Fixed and Dilated	Gauge: _____	❑ Ventilator	❑L ❑R	
				Site: _____	❑ NGT		
				Amount Infused: _____			
				❑ Bloods Drawn			

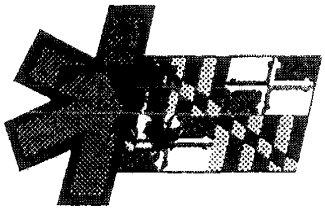
Assessment/Treatment: _____

_____

_____

Provider's Signature: _____ **Date:** _____ **Hospital Signature:** _____

Version 1/12



EMT Internship
PATIENT ASSESSMENTS

Name: _____
PLEASE PRINT

SSN: _____ Course No.:_____

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Patient _____

☐ Satisfactory
☐ Needs Remedial Practice Date:_____
☐ Satisfactory Remedial Date:_____

Comments:_____

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Student Signature: _____ Date_____

Field Training Coach: _____
PLEASE PRINT

Signature:_____ Date:_____

Maryland Institute For
Emergency Medical Services Systems

Patient Information Sheet

Incident # _____ **Date:** _____ **Time:** _____ **Arrived at Hospital:** _____ **Age:** _____ **Unit #:** _____

Gender: ❑M ❑F **Wt:** _____ Kg/Lbs **Trauma Category:** ❑A ❑B ❑C ❑D **Priority:** ❑1 ❑2 ❑3 ❑4 **Level of Consciousness:** ❑A ❑V ❑P ❑U

Patient Name: _____ **Date of Birth** _____ **Patient's Address:** _____

City: _____ **State:** _____ **Patient's Phone Number ( )** _____

Chief Complaint: _____

Past Medical History (DNR ❑ A1 ❑ A2 (DNI) ❑ B): _____

Current Medications: _____

Allergies: _____

Initial Vitals:	**Repeat Vitals:**	**Skin**	**Neurology**	**Cardiac Rhythm:**	**Oxygen**	**Respiratory**	**Pulse**
B/P: ____/____	**B/P:** ____/____	❑ Warm	❑ Alert	_____	❑ NR Mask	❑ Clear	❑ Regular
Pulse: _____	**Pulse:** _____	❑ Hot	❑ Verbal	**Glucometer:**	❑ Nasal Cannula	❑ Rales	❑ Irregular
Respirations: ____	**Respirations:** ____	❑ Cool	❑ Pain	_____	____ L/min.	❑ Labored	❑ Thready
SAO2: _____%	**SAO2:** _____%	❑ Dry	❑ Unconscious	**SAO2:** _____%	❑ BVM	❑ Stridor	Circulation
		❑ Clammy	**Pupils:**	❑IV1 ❑IV2	❑ ET ❑ NT	❑ Rhonchi	❑ JVD
		❑ Diaphoretic	❑ PERRL	❑IO ❑EJ	❑ Combitube	❑ Wheezes	❑ Edema Cap. Refill:
		❑ Cyanotic	❑ Unequal	Rate: _____	❑ CPR in Progress	❑ Decreased	____ sec.
			❑ Fixed and Dilated	Gauge: _____	❑ Ventilator	❑L ❑R	
				Site: _____	❑ NGT		
				Amount Infused: _____			
				❑ Bloods Drawn			

Assessment/Treatment: _____

_____

_____

Provider's Signature: _____ **Date:** _____ **Hospital Signature:** _____

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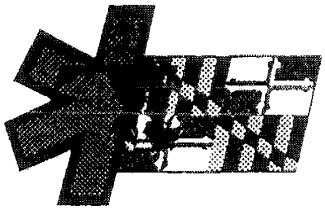


EMT Internship
PATIENT ASSESSMENTS

Name: _____
PLEASE PRINT

SSN: _____ Course No.:_____

The EMT students must assess and record assessments and care rendered on the ambulance runsheet (other side) for each patient:

- **Vital signs**
- **History**
- **Assessment**
- **Documentation of time**
- **Treatment provided**
- **Transport/communication**

NOTE: The student must complete a minimum of 5 satisfactory patient assessments

Patient _____

☐ Satisfactory
☐ Needs Remedial Practice Date:_____
☐ Satisfactory Remedial Date:_____

Comments:_____

_____

_____

_____

_____

BY MY SIGNATURE I HEREBY:

1. UNDERSTAND THAT ALL OF THE ABOVE INFORMATION I HAVE GIVEN IS SUBJECT TO VERIFICATION.
2. AFFIRM AND DECLARE THAT ALL OF THE ABOVE INFORMATION I PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.
3. ACKNOWLEDGE THAT ANY FRAUDULENT ENTRY MAY BE CONSIDERED SUFFICIENT CAUSE FOR REJECTION OR SUBSEQUENT REVOCATION

Student Signature: _____ Date_____

Field Training Coach: _____
PLEASE PRINT

Signature:_____ Date:_____

Maryland Institute For
Emergency Medical Services Systems

Patient Information Sheet

Incident # _____ **Date:** _____ **Time:** _____ **Arrived at Hospital:** _____ **Age:** _____ **Unit #:** _____

Gender: ❑M ❑F **Wt:** _____ Kg/Lbs **Trauma Category:** ❑A ❑B ❑C ❑D **Priority:** ❑1 ❑2 ❑3 ❑4 **Level of Consciousness:** ❑A ❑V ❑P ❑U

Patient Name: _____ **Date of Birth** _____ **Patient's Address:** _____

City: _____ **State:** _____ **Patient's Phone Number ( )** _____

Chief Complaint: _____

Past Medical History (DNR ❑ A1 ❑ A2 (DNI) ❑ B): _____

Current Medications: _____

Allergies: _____

Initial Vitals:	**Repeat Vitals:**	**Skin**	**Neurology**	**Cardiac Rhythm:**	**Oxygen**	**Respiratory**	**Pulse**
B/P: ____/____	**B/P:** ____/____	❑ Warm	❑ Alert	_____	❑ NR Mask	❑ Clear	❑ Regular
Pulse: _____	**Pulse:** _____	❑ Hot	❑ Verbal	**Glucometer:**	❑ Nasal Cannula	❑ Rales	❑ Irregular
Respirations: ____	**Respirations:** ____	❑ Cool	❑ Pain	_____	____ L/min.	❑ Labored	❑ Thready
SAO2: _____%	**SAO2:** _____%	❑ Dry	❑ Unconscious	**SAO2:** _____%	❑ BVM	❑ Stridor	Circulation
		❑ Clammy	**Pupils:**	❑IV1 ❑IV2	❑ ET ❑ NT	❑ Rhonchi	❑ JVD
		❑ Diaphoretic	❑ PERRL	❑IO ❑EJ	❑ Combitube	❑ Wheezes	❑ Edema Cap. Refill:
		❑ Cyanotic	❑ Unequal	Rate: _____	❑ CPR in Progress	❑ Decreased	____ sec.
			❑ Fixed and Dilated	Gauge: _____	❑ Ventilator	❑L ❑R	
				Site: _____	❑ NGT		
				Amount Infused: _____			
				❑ Bloods Drawn			

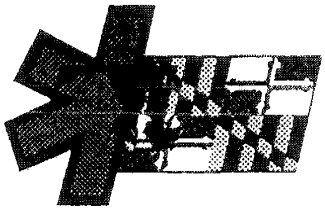
Assessment/Treatment: _____

_____

_____

Provider's Signature: _____ **Date:** _____ **Hospital Signature:** _____

Version 1/12



EMT Internship
PATIENT ASSESSMENTS

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Patient _____

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☐ Needs Remedial Practice Date:_____
☐ Satisfactory Remedial Date:_____

Comments:_____

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Student Signature: _____ Date_____

Field Training Coach: _____
PLEASE PRINT

Signature:_____ Date:_____

Maryland Institute For
Emergency Medical Services Systems

Patient Information Sheet

Incident # _____ **Date:** _____ **Time:** _____ **Arrived at Hospital:** _____ **Age:** _____ **Unit #:** _____

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City: _____ **State:** _____ **Patient's Phone Number ( )** _____

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Current Medications: _____

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Pulse: _____	**Pulse:** _____	❑ Hot	❑ Verbal	**Glucometer:**	❑ Nasal Cannula	❑ Rales	❑ Irregular
Respirations: ____	**Respirations:** ____	❑ Cool	❑ Pain	_____	____ L/min.	❑ Labored	❑ Thready
SAO2: _____%	**SAO2:** _____%	❑ Dry	❑ Unconscious	**SAO2:** _____%	❑ BVM	❑ Stridor	Circulation
		❑ Clammy	**Pupils:**	❑IV1 ❑IV2	❑ ET ❑ NT	❑ Rhonchi	❑ JVD
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		❑ Cyanotic	❑ Unequal	Rate: _____	❑ CPR in Progress	❑ Decreased	____ sec.
			❑ Fixed and Dilated	Gauge: _____	❑ Ventilator	❑L ❑R	
				Site: _____	❑ NGT		
				Amount Infused: _____			
				❑ Bloods Drawn			

Assessment/Treatment: _____

_____

_____

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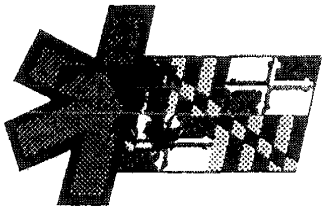
Version 1/12



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		❑ Clammy	**Pupils:**	❑IV1 ❑IV2	❑ ET ❑ NT	❑ Rhonchi	❑ JVD
		❑ Diaphoretic	❑ PERRL	❑IO ❑EJ	❑ Combitube	❑ Wheezes	❑ Edema Cap. Refill:
		❑ Cyanotic	❑ Unequal	Rate: _____	❑ CPR in Progress	❑ Decreased	____ sec.
			❑ Fixed and Dilated	Gauge: _____	❑ Ventilator	❑L ❑R	
				Site: _____	❑ NGT		
				Amount Infused: _____			
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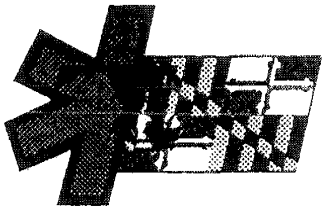
Version 1/12



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			❑ Fixed and Dilated	Gauge: _____	❑ Ventilator	❑L ❑R	
				Site: _____	❑ NGT		
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Assessment/Treatment: _____

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Version 1/12