Ride-Along/Job Shadowing

Emergency Information

Please Print

Full Name	Date of Birth
Street Address	City, State & Zip Code
Phone	Email

Notification in Case of Emergency

Full Name	Relationship
Phone	Email

Policy of Confidentiality and Dissemination of Patient Information

Given our nature of work, it is imperative that we maintain the confidence of patient information that we receive in the course of our work. **[ORGANIZATION NAME] prohibits the release of any patient information to anyone outside this organization.**

I understand that **[ORGANIZATION NAME]** provides services to patients that are private and confidential and that I must respect the privacy rights of its patients. I agree that I will comply with all **[ORGANIZATION NAME]** confidentiality policies and procedures during and after my Ride-Along.

Signature Date

Print Name

Release of Claims

WHEREAS, I, _____, not being a member of **[ORGANIZATION NAME]**, have made a voluntary request to ride as a guest in a vehicle/apparatus assigned to **[ORGANIZATION NAME]** and to accompany members of the organization during the performance of their duties, and I do hereby agree that the work of **[ORGANIZATION NAME**] could be dangerous and that I may be subjected to the risk of death, personal injury or damage to my property by accompanying members of the organization during the performance of their official duties and **I freely, voluntarily and with such knowledge, assume the risk or risks associated with such activities.**

Signature Date

Print Name