NorthShore
University HealthSystem

Highland Park Hospital
EMS System

It is the individual's responsibility to notify the EMS office of any change on this form within 10 days.

ECRN Information Form

Date:_____ Hospital:_____

Name: _____

Home Address: _____

Town:_____State: _____

Zip Code:_____County: _____

Home Phone:_____Cell Phone: _____

D.O.B.:_____ Male:____Female: ____

Work E-Mail Address: _____

Home E-Mail Address: _____

ECRN: Training Site: _____

Date Completed: _____

ECRN State License Number: _____

Expiration Date: _____

Note: Please be advised that a Social Security number and Driver's License or State ID number are required during the initial licensure and relicensure process. Contact the EMS office with questions.