

Gila River Health Care EMS RIDE-ALONG PACKET

All riders must complete this packet and turn it in to an officer for approval. Ride-alongs are NOT permitted unless this packet is complete and approved by an EMS Officer.

RIDER INFORMATION

FULL LEGAL NAME: _____

DOB: _____ PHONE #: _____

EMAIL ADDRESS _____

ADDRESS (STREET) _____

CITY, STATE, ZIP: _____

REQUESTED RIDE ALONG DATES: _____

EMERGENCY CONTACT

NAME: _____ RELATION TO RIDER: _____

PHONE #: _____ ADDRESS (STREET) _____

CITY, STATE, ZIP: _____

APPLICATION APPROVAL (FOR DEPARTMENT USE ONLY)

REVIEWED BY: _____ DATE: _____

ALL FORMS AND SIGNATURES COMPLETE? YES: NO:

APPROVED: DENIED: DENIAL REASON: _____

APPLICANT NOTIFIED OF DENIAL OR ACCEPTANCE ON (DATE): _____

Gila River Health Care EMS RIDE-ALONG GUIDELINES

There are inherent risks involved in participating in a ride-along and all riders are required to fully read, understand, and agree to the instructions and waivers in this packet. With the appropriate safeguards, non-EMS personnel can ride safely and gain a good perspective on EMS operations and the types of services Gila River Health Care EMS provides.

DRESS/EQUIPMENT

All riders are expected to wear appropriate attire while on a ride-along. This includes: pants/jeans (no shorts) in good repair and closed toed shoes or boots. Shirt must not contain any vulgar and/or offensive advertising or emblems. A Gila River Health Care EMS traffic vest will be worn anytime outside of the station.

CONDUCT/SAFETY

All riders are expected to strictly adhere to the safety and conduct guidelines outlined below.

- You must follow ALL directions given to you by EMS personnel.
- At the direction of the crew, you must wear any necessary personal protective equipment.
- You must, at all times, be in the immediate vicinity of the EMS crew unless directed otherwise. If you need to leave the station, ambulance, or crew for any reason, you must notify the EMS personnel.
- You must wear a seatbelt at all times when riding in a vehicle that is in motion.
- You are expected to behave professionally and courteously to patients, bystanders, crew members, and other agencies involved with a call.
- You must immediately report any injury, illness, or other problem to a crew member.

A rider who violates any safety or conduct guideline may have their ride-along terminated.

Please carefully read and agree to the following statement:

I, _____, have read the above Gila River Health Care EMS ride-along guidelines and I agree to abide by them. I understand that a violation of any of the above policies is grounds for termination of my ride-along.

Rider's Signature _____ Date _____

Gila River Health Care EMS WAIVER OF RIGHTS

In participating in a ride-along with Gila River Health Care EMS, the undersigned waves any and all rights that he or she might have to claim damages, compensation, or remuneration in any form from Gila River Health Care EMS, Gila River Health Care, Gila River Indian Community, and employees arising from or associated with the ride-along.

These rights specifically pertain to any injuries to the undersigned while he/she is a passenger in any ambulance or other vehicle owned or operated by Gila River Health Care EMS, Gila River Health Care, Gila River Indian Community, or to any injuries sustained in the course of responding to a call including while en route, on scene, or at any facility.

The inherent dangers associated with a ride-along include, but are not limited to, accidents involving the ambulance, negligent or intentional tortuous acts by third party persons, exposure to communicable diseases, and various accidents during the provision of emergency medical treatment. I also understand that I may witness traumatic injuries or events that may leave a lasting impression.

As used herein, the word "injuries" shall include bodily injuries, injuries to personal properties, mental anguish, emotional distress and/or death resulting from any such bodily injuries. All reference herein to the undersigned shall include not only the individual actually signing this document, but also his or her personal representative, heirs, and survivors.

In addition to waiving rights as specified above, the undersigned, by signing this document, represents that he/she has read, understood, and received a copy of this document; that he/she is 18 years of age or older; and that he/she is fully aware of the risks inherent in participating in the ride-along. The undersigned also acknowledges that if any single provision of this Waiver of Rights is declared unenforceable that such declaration has no effect on the enforceability of the remainder of the Waiver. This Waiver of Rights shall become effective upon its signing.

Rider's Signature _____ Date _____

Witness Signature _____ Date _____



Acknowledgement of Confidentiality

As a guest of Gila River Health Care (GRHC), I understand GRHC's commitment to protect patients' right to privacy in accordance with organizational policies and procedures and applicable tribal, federal and state laws. I also understand GRHC's responsibility to maintain the privacy and confidentiality of all information pertaining to patient treatment.

As part of my visit, I may be exposed to certain private and confidential information relating to patient treatment. As consideration of GRHC allowing me to visit its facilities, I agree to comply with all privacy rules, procedures and policies adopted by GRHC. I also agree to comply with all privacy requirements established by the Health Insurance Portability and Accountability Act (HIPAA), its related regulations and standards, and all applicable federal and state privacy and confidentiality laws. I shall also be bound to any additional considerations and commitments to patient privacy and confidentiality as are required of GRHC personnel.

Without limiting the foregoing, I agree not to divulge any information I acquired as a guest at any one of our facilities, either verbally, in print or otherwise, except as required by applicable law. This agreement also extends to the prohibition of any disclosure, although not patient specific, in which the identity of any patient is or may readily be ascertained. I agree not to interact with any patients and/or their families that I may come in contact with during my visit. I shall return any written document and/or electronic media that I receive during my visit at the conclusion of my visit if so requested by GRHC personnel.

Name (printed)	Signature
Date of Visit	Sponsor (Employee)