Northwest Community EMS System

ECRN EDUCATION PROGRAM
2026 APPLICATION

STUDENT INFORMATION (Please type or print legibly)	
Student name:	Date of birth:
Address:	Illinois nurse license #:
City:	Illinois driver's license #:
State: Zip:	Social Security #:
Phone #:	e-mail address:
Employer:	
Supervisor name:	
Attach verification of ECG interpretation review course or online module if completed *(not mandatory but highly recommended)*	**Who is responsible for tuition payment?** ☐ Student ☐ Hospital

ED EXPERIENCE VERIFICATRION

Must be signed by either the ED Supervisor or Hospital EMS Coordinator of the employing hospital

EMPLOYER AGREEMENT:

I hereby affirm that the applicant is currently employed as an RN, has successfully completed their ED orientation, and is in good standing with this hospital. We agree to resource, equip, and support this participant during their ECRN education, provide opportunity for supervised on-line medical control experience, and assist in the completion of all ECRN certification requirements.

_____

PRINT NAME / Signature of employer administrative representative

Title: _____

APPLICANT AGREEMENT

I hereby affirm that the above demographic information is true and correct. I understand that false information may be considered as sufficient cause for denial of entry and/or removal from the ECRN training program.

_____

Signature of applicant: Date:

Please submit the completed application to the NWC EMS Office

Attn: Pam Ross | pamela.ross@endeavorhealth.org

Payment information:

Tuition: $200

Payable to Northwest Community Hospital - **Cost center**: EMS Resource Hospital 1201101532

Questions? Call 847-618-4482 or 618-4488

For office use only:
☐ Payment received: