



County of San Diego

Application for Out-of-County Paramedic Internship

Name: _____

Address: _____

Phone Number: _____

Email Address: _____

Out-of-County Paramedic Training Program

Name: _____

Address: _____

Phone number: _____

Training Program Contact Person: _____

Phone Number: _____

Email Address: _____

County of San Diego ALS Provider Agency

Name: _____

Contact Person: _____

Phone Number: _____

Email Address: _____

Preceptor: _____

Preceptor Phone Number: _____

Preceptor Email Address: _____

Estimated Completion dates: Clinical: _____ Field: _____

Intubations completed

Appropriate immunizations received

Training Program Signature: _____

----- County Use Only -----

CPR/ACLS Verification: _____

EMT Certificate Number: _____ Exp. Date: _____

Accreditation Class Completion Date: _____

J Number Assigned: _____ Exp. Date: _____