TOWN OF MACEDON AMBULANCE SERVICE
Ride-Along Program

Purpose

The purpose of this program is to allow interested persons to ride on a Town of Macedon Ambulance with Macedon Town Ambulance personnel, during part of their shift. The program is designed to increase awareness of Macedon Town Ambulance's emergency services, through direct contact with the Emergency Medical Services personnel and their work at the scene of an accident, illness, fire or other incident. Individuals ages 16 years of age and older who may be interested in working or volunteering for Macedon Town Ambulance and who meet our other eligibility requirements are eligible to request participation in our Ride-Along Program.

Procedure

Persons wishing to participate in the Ride-Along Program must obtain a Ride-Along Application, fill it out and return it at least five (5) business days prior to the anticipated date of the ride. When returning the Application, you will be required to sign the Liability Waiver Form in the presence of the Administrator or his/her designee.

The following guidelines apply to anyone requesting to participate in the Ride-Along Program.

- Macedon Town Ambulance has the authority to approve or deny any request for participation in this program, or alter such request in the best interest of the Ambulance service.
- Participants must be 16 years of age or older to participate in the Ride-Along Program. Students enrolled in an Emergency Medical Technician (EMT) class will be given special consideration.
- Participant's attire shall be professional with comfortable shoes. Nursing students may wear scrubs. Dress appropriately for weather conditions.
- Macedon Town Ambulance has the authority to revoke an authorization at any time if a participant's conduct is not in the best interest of the Ambulance service.
- The participant's ride shall last no longer than 12 hours. Participants may not ride before 8:00 a.m. or later than 10:00 p.m.
- The participant may only observe operations/activities from a safe location. No Ride-Along participant is allowed to engage in, or otherwise participate in, patient care operations at the incident scene.
- Participants may be subject to a fee for the criminal history record check.

My Signature ____________________________________this ____day of _________________, _______.

My Printed Name.___________________________________.

Parent/Legal Guardian ______________________________ Printed Name _________________________

Witness Signature ________________________________this _____ day of ________________, _______.

TOWN OF MACEDON AMBULANCE SERVICE

Ride-Along Participation Agreement

Assumption of Risk, Indemnity Agreement, and Covenant not to Sue

I, ______________________________ have requested that Macedon Town Ambulance allow me to come onto MTA facilities and to ride with Ambulance personnel on emergency equipment as part of MTA's Ride-Along Program. I am fully aware of the inherent risks associated with my participation in MTA's Ride-Along Program, which include, but are not limited to bodily injury, physical disability, physical and mental diseases, death, and property damage resulting from the risks of motor vehicle accidents, exposure to infectious / contagious diseases, accompanying fire & EMS personnel into high crime areas and the general uncertainty surrounding the provision of emergency services. Understanding these risks, it is still my decision to participate in the Ride-Along Program and in consideration of Macedon Town Ambulance allowing me to participate; I assume full responsibility for such risks. I agree that neither I, or my legal representatives, heirs, and assigns, will hold Macedon Town Ambulance, its officials, employees or agents, responsible for any injuries, disabilities, physical and mental diseases, death, property damage, or losses and expenses of any nature whatsoever that I may sustain as a result of my participation in the Ride-Along Program, whether caused by the negligence of MTA, its officers, employees and agents, or otherwise.

I further agree to indemnify, hold harmless, and to assume the defense of Macedon Town Ambulance, its officers, employees and agents, from all claims and expenses of any nature whatsoever, including the cost of defending such claims which may accrue against, be charge to, or recovered from or sought to be recovered from MTA, its officers, employees and agents, as a result of my participation in MTA's Ride-Along Program.

I understand that this Agreement is intended to be as broad and inclusive as permitted by the laws of the Commonwealth of New York, and that if any portion thereof is held invalid, it is agreed that the balance shall, not withstanding, continue in full force and effect.

I further understand that permission to participate in MTA's Ride-Along Program is granted subject to the rules and regulations of MTA and such permission may be restricted to specified periods of time or revoked entirely by MTA in its sole discretion. I agree to follow all Rules, Regulations and Procedures of MTA during my participation in MTA's Ride-Along Program. I further state that I am at least sixteen years of age; that I have carefully read the foregoing Release, and know the contents there, and that I am signing this Release as my own free Act.

My Signature ______________________________________this _____ day of ________________, ___________.

Parent/Guardian Signature ____________________________this _____ day of ________________,___________.

Witness Signature __________________________________this _____ day of ________________, ___________.

CAUTION: READ BEFORE SIGNING

TOWN OF MACEDON AMBULANCE SERVICE
Ride-Along Program HIPAA Participant Agreement

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (as amended) limits Macedon Town Ambulance's disclosure of the protected health information of any patient to specific uses such as the provision of treatment or other health care services, for billing and payment purposes, and for health care operational purposes. Additionally, Macedon Town Ambulance is authorized to release health information for a number of specialized purposes (to assist in the prevention or control of public health risks, selected assistance to law enforcement agencies, assistance to federal officials in the interests of national security, etc.).

As a participant in Macedon Town Ambulance's Ride-Along Program, you are specifically prohibited from discussing individual patients, their treatment, and any other information that could be utilized to identify these patients with anyone except those Macedon Town Ambulance personnel who will be conducting your ride along activities. Any disclosure of patient information as detailed above may subject you to civil and/or criminal penalties as prescribed by law.

Should special circumstances necessitate that you utilize or disseminate such information; Macedon Town Ambulance's Privacy Officer will assist you in ensuring that the material is in such form that it cannot be utilized to identify a specific patient. No health-related information may be utilized without review and subsequent authorization of the Privacy Officer, unless a patient(s) authorizes its dissemination in writing via a release form.

As a participant in Macedon Town Ambulance's Ride-Along Program, I understand the restrictions outlined above and I agree to abide by the requirements of this Agreement. I understand that I may be subject to civil or criminal penalties should I violate the prohibitions set forth in the Health Insurance Portability and Accountability Act of 1996, as amended.

____ ________________

Ride-Along Participant Signature Date

____

Ride-Along Participant Printed Name

____ ________________

Witness Signature Date

TOWN OF MACEDON AMBULANCE SERVICE
Ride-Along Application

Application must be filled out prior to participation and returned in person to the Director of EMS.
NO ONE will be allowed to participate unless all necessary paperwork is completely filled out and signed.

APPLICANT INFORMATION

Please fill in the information requested below. Prior to you being allowed to participate, the assumption of risk agreement must be completed with your signature being witnessed by a representative of the Macedon Town Ambulance Service. The completed form must be returned at least five business days prior to your requested participation. Any false information or omissions on this application may result in disqualification for ride-along privileges. Macedon Town Ambulance Service reserves the right to deny ride-along privileges for any reason, without prior notice. After your form has been submitted, contact the Director of EMS at (315) 986-2309 ext. 1 to verify approval.

Full Name		Date of Birth
Home Address		HM/WK Phone Number
Social Security Number		Cell Phone Number
Place of Employment or School		Gender (circle): Male Female
Position/Title	Major/Study	
Place of Employment/School Address		Business/School Phone #:
Organization(s) Represented		
What is your interest in participating in this program?		
Date you are requesting to "Ride-Along"	Unit You Wish To Ride	How did you become aware of this program?
Time you wish to "Ride-Along" (Must be after 8:00 a.m. but before 10:00 p.m. and for no more than 8 hours total.)		

Please answer the following by placing a 'Y' for yes, or an 'N' for no, in the box to the right of the question:

Question	Y/N	Question	Y/N
Are you subject to a court order restraining you from harassing, stalking, or threatening an intimate partner or child of such a partner?		Have you ever been charged or convicted of a criminal offense? Please list the offense, date, and location: ____________ ____________	
Are you under indictment or do you have charges pending in any court for any crime?		Are you currently taking any medication that could impair your judgment in a stressful situation?	
Have you ever participated in this program? If yes, when did you last participate?		Are you an unlawful user of marijuana, any depressant or stimulant, or any controlled substance?	

I have read and understand the procedure for the Ride-Along Program of ______________________. The above information is true and accurate to the best of my knowledge.

Signature of Applicant: ____

FOR DEPARTMENT USE ONLY

Approved: ☐ Yes ☐ No
Signature: ______________________________________
Comments: ______________________________________
____
Rode with: ______________________________________

__ Failed to appear
__ Refused to allow applicant to ride
Explain:______________________________________
__ Terminated applicant's ride before scheduled time
Explain:______________________________________

AUTHORIZATION TO PERFORM CRIMINAL HISTORY RECORD CHECK FOR RIDE-ALONG PROGRAM OF TOWN OF MACEDON AMBULANCE SERVICE

NAME (First, Middle, Last)____Gender Male / Female

MAIDEN NAME (If applicable)____

CURRENT ADDRESS: ____HOW LONG?___________________

CITY, STATE, ZIP: ____

1ST PREVIOUS ADDRESS____HOW LONG?___________________

CITY, STATE, ZIP: ____

APPLICANT SOCIAL SECURITY NUMBER: _________ - _______ - ________ DATE OF BIRTH____/_____/____

DRIVER'S LICENSE # AND STATE ISSUED: ____

APPLICANT AUTHORIZATION

I hereby authorize Macedon Town Ambulance to conduct or have another entity conduct a criminal history record check. I agree to pay Macedon Town Ambulance up front for the full cost of obtaining this criminal history record check.

I understand that Macedon Town Ambulance does not guarantee the accuracy or timeliness of the information obtained from other sources and that Macedon Town Ambulance will not be liable for any inaccuracy in the information obtained from other sources that are included in the criminal history record check.

Further, I authorize other organizations to provide such information to Macedon Town Ambulance and I hereby release and hold harmless Macedon Town Ambulance as well as other entities that have provided information in connection with my criminal history record check.

CONSUMER DISCLOSURE

I understand that I may obtain a copy of the criminal history record check for screening purposes.

____ ______ / ______ / _______

APPLICANT'S SIGNATURE **DATE**