

Confidentiality of Patient Information
Ride-Along Program Participant Verification

I understand that Air Methods Corporation provides services to patients that are private and confidential. I understand that in the rendering of emergency medical services, that patients provide personal information and that such information may exist in a variety of forms such as electronic, oral, written or photographic and that all such information is strictly confidential and protected by federal and state laws.

I understand that I am prohibited from sharing patient information, in any format, with anyone unless required to do so. I agree that I will comply with all confidentiality policies and procedures set in place by Air Methods Corporation during my Ride-Along. If I, at any time, knowingly or inadvertently breach the patient confidentiality practices, I agree to notify the Privacy Officer of Air Methods Corporation immediately. In addition, I understand that breach of patient confidentiality may result in termination of current and future opportunities to participate in the Ride-Along Program.

I have read and understand the HIPAA policy and the privacy practices of Air Methods Corporation. I agree to abide by all practices and policies.

Signature

Date

Printed Name

**RIDE-ALONG PARTICIPANT
WAIVER OF LIABILITY, HOLD HARMLESS AGREEMENT**

NAME: _____ **NEAREST RELATIVE:** _____

ADDRESS: _____ **RELATIVE**
CITY, STATE: _____ **ADDRESS:** _____

PHONE: _____ **CITY, STATE** _____

I, _____, request permission to ride along in an Air Methods Corporation helicopter. In consideration for being granted permission to ride in an Air Methods Corporation helicopter, I hereby indemnify, hold harmless, release and discharge Air Methods Corporation and any of its officers, employees and agents from any liability to me, my employer, my assigns, my heirs, my executors and personal representatives now and forever, for any claim by reason or on account of injury to myself or my property, whether by reason of accident, intent or neglect during such time that I am in a vehicle or aircraft Air Methods Corporation, or in the company of an officer, employee or agent of Air Methods Corporation who is discharging his/her duties.

In addition, I agree to indemnify and hold harmless Air Methods Corporation, its employees, agents and assigns for any and all claims, losses or liability which arise as a result of my conduct, whether it be negligent or accidental while I am a participant in the Ride-Along Program, including, but not limited to such times that I may be in an Air Methods Corporation helicopter or in the company of an officer, employee or agent of Air Methods Corporation while he/she is acting or discharging his/her duties on behalf of Air Methods Corporation.

I further agree to abide by all rules and regulations applicable to the Ride-Along Program. I have been advised, and am aware of the risks and dangers associated with emergency medical transport. I agree to respect the confidential nature of all information with regard to the patients and transports and to comply with the confidentiality policies and procedures established by Air Methods Corporation. I understand that Air Methods Corporation provides emergency medical services to patients and will respect the privacy rights of the patients.

I assume all risks of death, injury, loss or damages to my person or property, whether due to accident or neglect, and neither I nor any of my representatives shall have any claim against Air Methods Corporation, their officers or employees, by reason of my death, injury, loss or damage.

Signature of Applicant: _____

Witness: _____ Date: _____

**AIR METHODS CORPORATION
RIDE-ALONG APPLICATION**

PLEASE FOLLOW DIRECTIONS BELOW:

1. Fill out application completely. Application and waivers must be received prior to Ride-Along. It is your responsibility to follow-up and confirm the class you have requested.
2. Applicant must be 18 years of age or older and ***may be eliminated from program based upon weight, aircraft performance, or PIC decision.***
3. A copy of current licensure should be submitted with application (if applicable).
4. You must be employed or volunteer for a public service entity or in a hospital setting.

NAME: _____ ORIENTATION DATE: _____

ADDRESS: _____ WEIGHT: _____

CITY/STATE/ZIP: _____ AGE: _____

AGENCY AFFILIATION: _____

PHONE (DAY): _____ EVENING: _____

NAME OF EMERGENCY CONTACT: _____

PHONE (DAY): _____ EVENING: _____

What are your reasons for wishing to participate in the Ride-Along Program?

Ride-Along Signature

Date