



Paramedic Program

Dear Applicant:

We appreciate your interest in the _____ Paramedic Program and the following is attached:

1. Application Checklist
2. Application Forms
3. Medical History Form
4. Physical Examination Form

The completed application and all requested documentation must be submitted no later than 60 days prior to the beginning class date you have selected. Applications will be considered on a case-by-case basis if received less than 60 days before the scheduled class date.

The _____ Program is accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and adheres to the latest guidelines as set forth in the National Emergency Medical Services Education Standards.

If you have questions, please feel contact me at Lisa.Smith@amr.net or (916) 960-6286.

Sincerely,

Lisa Smith
Student Registration Coordinator



Application Packet

Application Checklist

Each of the items listed is required to complete your application. Applications that are incomplete at the cut-off date are considered for the next session. Obtain or complete each of the items and forward to Lisa Smith.

1. Application, completed and signed.
 2. Copy of high school diploma or equivalent or official transcript of an Associate or Bachelor degree.
 3. Copy of current State or County EMT card or NREMT Card
 4. Driver's license / government issued ID and birth certificate OR a copy of valid US Passport.
 5. Copies of college official transcripts, if applicable.
 6. Record of recent physical exam (within 6 months) on the form provided in the application packet.
 7. Proof of completion of the hepatitis vaccination series, MMR, Hep B, T-dap, meningitis, and chicken pox vaccination – T-Dap must have been completed within the last 10 years
 8. Provide proof of current health insurance.
 9. Sign and date the Application Checklist indicating each step has been completed. Mail or scan and email the checklist with your application to the **NCTI Business Office: Email: Lisa.Smith@AMR.net or Mail to NCTI 333 Sunrise Ave Ste 500 Roseville, CA 95661**
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The student is responsible for making all necessary arrangements to renew certifications that expire during the term of the Paramedic Program.

Signature

Date



Application Packet

Please type or print:

Name	Date of Application:
	Date of Desired Course:
Address:	Social Security
	Date of Birth:
Phone:	EMT Certification # and State:
E-Mail Address:	
Current EMS Affiliation:	Expiration Date:
Affiliation Address:	Emergency Contact
	Name:
Affiliation Phone:	Relationship:
Name of Supervisor:	Phone #:

=====

Office use only

Date Application Received:	Health Insurance:	Previous EMS Experience:
Hep B Vaccination Dates: 1. 2. 3.	MMR Vaccination: 1. 2.	Chickenpox Vaccination:
TDaP Vaccination:	TB Test:	Flu:
Meningitis Vaccination:	Physical Exam Form Completed:	EMT/NREMT Expiration Date:
BLS Expiration:	High School transcript:	Driver's License:
College Transcripts:	Anatomy and Physiology	Proof of Citizenship



Application Packet

Formal Education

	Institution	Location (City, State)	Highest level completed	Diploma or Degree	Date Finished
High School					
College					
Graduate School					
Other (describe)					

EMS Training Completed:

(List most recent training in each category as applicable)

	Institution	Location	Instructor	Date Completed	Exp. Date
AHA BLS					
EMT					
Advanced EMT					
ACLS					
PALS / PEPP					
ITLS / PHTLS					
Other					



Application Packet

Work Experience:

Record all places of employment (full or part-time) for the past five years, listing present and/or most recent first. Use an additional page if more space is needed.

Employer Name	Employer Address	Position	Supervisor Name	Dates of Employment	Reason for Leaving



Application Packet

Attestation

Have you ever been convicted of a crime or violation of any State or Federal law regulating the possession, distribution, or use of any narcotic drug? Yes No

Do you have an addiction to or dependence upon alcohol, barbiturates, amphetamines, hallucinogens, or other drugs or substances having a similar effect? Yes No

I do hereby certify that:

1. I am the applicant named and that I am requesting admission to the Paramedic Program identified herein;
2. I have read and understand the Paramedic student prerequisites and do hereby meet those prerequisites unless exceptions have been identified above.
3. I understand I must submit proper documentation of physical examination and proof of required vaccinations prior to acceptance;
4. I understand that entrance into the program does not guarantee Paramedic certification;
5. I understand that completion of this education program will not authorize or grant me any right to perform those advanced life support activities in which I will be trained, as these acts are governed by the State. Any right to perform such acts must be acquired only by agreement with a medical advisor and under the authority of his/her medical license;
6. I understand that approved continuing education courses and on-going review and audit with an agency medical director will be part of the requirements necessary to maintain Paramedic certification;
7. I have read all of the above statements and do declare these statements to be true to the best of my knowledge;
8. I understand that all statements made in this application are subject to verification and should falsification of this document be demonstrated, my application shall be considered unacceptable for admission to the Paramedic Program.

Name

Signature

Date



Application Packet

Health and History Questionnaire

One way to help eliminate the risk of persons being placed into situations that would pose undue risk of illness or injury to themselves, or to other personnel is to complete a health and work history form. Program staff will review this form. Please answer the following questions completely & frankly.

All medical information will be kept in strict confidence in your file.

Name: _____ Address: _____
Telephone #: _____
Birth date: _____ Sex: Male Female

Please answer all questions to the best of your knowledge. Any omissions, exclusions or falsifications on this questionnaire can result in eliminating you for consideration of acceptance in the Paramedic Program.

Your present health is: Good Fair Poor

Health History

Check Yes or No for the following if you have or have ever had:	Y	N		Y	N
Hospitalized in past 5 years		<input type="checkbox"/>	Back problems		<input type="checkbox"/>
Currently pregnant			GI disease/ulcers		
Psychiatric disorder/treatment			Liver disease/gall bladder		
Received a transfusion			Hernia		
Chest x-ray – date of last one			Hemorrhoids		
Headaches			Kidney disease		
Epilepsy/seizures			Knee problems		
Neck problems			Foot problems		
Shoulder problems			Skin problems or dermatitis		
Tendinitis/carpal tunnel/upper extremity problem			Arthritis		
Heart problems			Cancer		
High blood pressure			Diabetes		
High cholesterol			Surgery		
Lung problems/asthma			Rheumatic fever		
High/Low Thyroid					

If yes to any of the above, please explain:



Application Packet

Infections disease/vaccinations (Check Yes or No for the following)

Have you ever had:	Y	N	Have you ever received:	Y	N
Rubella (German Measles)*			Rubella (German Measles) vaccine		
Rubeola (Measles)*			Measles (Rubeola) vaccine		
Chicken pox (Varicella)*			Chicken pox (Varicella) vaccine		
Hepatitis B			Mumps vaccine		
Hepatitis – other than Hepatitis B			Hepatitis B vaccine - List Dates:		
Tuberculosis (TB)					
Mumps*			Tetanus shot - List Date:		
Strep infection			Meningitis		

If yes to any of the above, please explain:

* Proof of vaccine must be documented if not had the diseases.

Allergy History

Check Yes or No for the following:	Y	N		Y	N
Dust			Smoke		
Fumes			Tetanus toxoid		
Seasonal pollen/grasses/molds			Latex sensitive		
Medications/sensitive			Chemicals/sensitive		

If yes to any of the above, please explain:

List any medications you have taken in the past 3 months:

Occupational Work History

- Do you currently have any physical, emotional, or medical limitations that would interfere with your ability to perform the activities required in the Program? Yes No

If yes, please explain: _____



Application Packet

2. To the best of your knowledge, would participation in the Program aggravate any previous or known physical, mental, or medical impairments? Yes No
 If yes, please explain: _____

3. Have you ever been unable to work for an extended period of time (more than 2 weeks) due to any physical, medical, or mental condition? Yes No
 If yes, please explain: _____

4. Have you ever had an on-the-job accident or occupational illness? Yes No
 What kind of injury or illness did you sustain? Please list dates, time missed from work and injury:

Were you hospitalized? ? Yes No Please list dates: _____

Did you receive permanent work restrictions? Yes No

Check Yes or No for the following:	Y	N		Y	N
Exposed to asbestos?			Any permanent disability or impairment?		
Exposed to excessive noise? (machines, shooting)			Exposed to chemicals at work?		
Worn film badge?			Ever worn hearing protection?		
Had an overexposure to ethylene oxide?			Worked with ethylene oxide?		
Exposed to heavy metals, carcinogens, and lasers?			Worked with formaldehyde?		

If yes to any of the above, please explain:

I certify that the answers and information given by me to the questions and statement contained in this questionnaire are true and correct to the best of my knowledge without omissions of any kind whatsoever, and understand that falsification, omissions, or misstatements are grounds for disqualification. I agree that _____ shall not be liable in any respect if I am disqualified because of falsity of statement answers or omissions made by me in this questionnaire.



Application Packet

Health History Form

(To be completed by Licensed Physician or Mid-level Practitioner)

Patient's Name: _____ Age: _____

Blood pressure: _____ Pulse: _____ Height: _____ Weight: _____

Vision: Corrected Uncorrected

Far:	O.D.	20/	Near:	O.D.	20/
	O.S.	20/		O.S.	20/
	O.U.	20/		O.U.	20/

Color (Ishihara): _____

Rubella titer: _____
(or documentation of immunization)

Lab: Rubella titer (IGG) _____

- Or,**
- if DOB > January 1, 1957, documentation of two immunizations
 - if DOB < January 1, 1957, documentation of one immunization

Varicella titer (if hx negative) _____

Hepatitis B titer (if hx negative) _____
(or documentation of Hep B series)

PPD or CXR _____

Other _____



Application Packet

Physical Exam

General Appearance	Normal	Abnormal (Describe Below)	General Appearance	Normal	Abnormal (Describe Below)
Head / Neuro			Eyes		
Ophthalmoscopic exam			Ears		

Nose			Mouth & teeth		
Throat			Neck		
Skin			Chest & breast		
Lungs			Heart		
Pulses			Abdomen exam / Hernia		
Liver/spleen			Upper extremities		
Lower extremities			Spine		

Comments/Recommendations: _____

Restrictions: _____

Signature (MD/DO completing physical)

Name (please print)

Date



Application Packet

Accreditation

The Program is accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) upon the recommendation of Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions CoAEMSP.

CAAHEP

25400 US Highway 19 N., Suite 158
Clearwater, Florida 33753
(727) 210-210-2350
(www.caahep.org)

The accreditation of Paramedic programs is based on the *Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions* established by the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions and the Commission on Accreditation of Allied Health Education Programs. Information on the *Standards* can be obtained by visiting www.coaemsp.org or contacting the executive office at:

CoAEMSP

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Suite 111-312
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