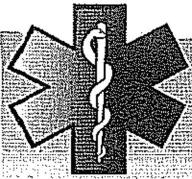

PARAMEDIC

REGIONAL PROGRAM

Distance Learning Paramedic Program 2015

Applications are due by Nov. 21

Late applications will be considered up to the class start date: Jan. 5

Class runs

Monday and Thursday nights from 6:30pm until 10:30pm

**Some weekends will be required*

Class locations:

Olean General Hospital 515
Main Street
Olean, NY 14760

ALSTAR EMS Training Center
335 East Third Street
Jamestown NY 14701

**We are currently in the application process for a third site in Allegany County. The application for the Allegany County site has not yet been approved by the NYS EMS DOH, but may become available in 2015.*

Acceptance letters will be sent out to students starting 11/03/2014.

Initial course applications should include a medical and immunization screening.

Tuition is $3,150. This does not include books.

Those students who belong to an ALS EMS agency that maintains eligibility for NYS reimbursement will only be responsible for $1,500 and book fees. *Students who are not eligible or fail to maintain eligibility are responsible for the full amount of $3,150 plus books.*

Advanced students and RN's seeking advance standing status will be sent a packet containing directions for this process and should be prepared to test on Dec 13th from 9am-12pm and 2pm-5pm at both locations.

For detailed information please contact us at the ALSTAR EMS Training Center 716-664-8319 for assistance.

PARAMEDIC
REGIONAL PROGRAM

2015 Paramedic Application

ALSTAR EMS Training Center
335 East Third St
Jamestown NY 14701
Phone 716-664-8319 Fax 716-484-8886
anna.estus@wcaservices.com

FIRST NAME

LAST NAME

ADDRESS

CONTACT PHONE

DOB

EMAIL

PRIMARY EMS AGENCY

EMS Level: ☐ EMT ☐ AEMT ☐ CRITICAL CARE ☐ RN

Expiration Date: ______________________ *(Card must be valid through 12/17/2015)*

EMS or RN #: ________________ Years EMS Experience: ________________

Primary Class Location Site: ☐ Jamestown ☐ Olean

If my first choice is full I would be willing to travel to the other class location: ☐ Yes ☐ No

I will be requesting advance standing credit for this course: ☐ Yes ☐ No

Shirt Size (Polo): ____________________________

(Choose wisely this will be your class clinical shirt order based on men's sizes)

EMERGENCY CONTACT

EMERGENCY CONTACT PHONE

I HAVE INCLUDED THE FOLLOWING ITEMS WITH THIS APPLICATION:

☐ Copy of my current EMS Card

☐ My completed physical and proof of required immunizations records (1, 2 & 3)

☐ I am requesting advance standing and I am including a letter from my area Medical Director, call or run record report, previous clinical records or proof of experience

I,________________________________, understand that my medical history as reported on my program application may be requested by the W.C.A. Services Corp. and various clinical site agencies. I understand that by signing this form, I agree to allow the ALSTAR EMS Training Center to release my medical history to any requesting clinical site agencies upon their request.

My signature below confirms my acceptance of the above. I understand this is my course application and is not guaranteed acceptance into the paramedic program. If I am selected I will be able to commit to the program and meet all program requirements for admission.

Signature of Applicant____ Date____________

I, as the applicant, hereby certify that all of the information contained in this application is true and correct and that the signature below is mine as applicant. I further understand that offering or providing false information on this document may constitute a crime under the penal law. I do affirm that I have not been convicted nor am I currently charged with any crime(s) related to: murder, manslaughter, assault, sexual abuse, theft, robbery, drug abuse or the sale of drugs.

Signature of Applicant____ Date____________

PHYSICIAN STATEMENT & RELEASE

Name of Student: ______________________________ EMS Agency: ___________________________

Address: ____

____

Student's Date of Birth: ____

Physician's Statement: "I have performed a medical evaluation and reviewed the student's health history. I have the student's Health History & Medical Record on file. I found the above named student, to the best of my knowledge, to be free from physical or mental impairments including habituation or addiction to depressants, stimulants, narcotics, alcohol or other behavior altering substances which might interfere with the performance of his/her duties or would impose a potential risk to patients of personnel."

The following immunizations, history or tests have been completed or confirmed:

Measles	Yes ( )	No ( )	
MMR	Yes ( )	No ( )	
Chickenpox (Varicella)	Yes ( )	No ( )	
Rubella	Yes ( )	No ( )	
Hepatitis B	Yes ( )	*No ( )	*Declaration Date: ______________
PPD	Yes ( )	No ( )	
Tetanus Booster	Yes ( )	No ( )	
Diphtheria	Yes ( )	No ( )	
Influenza Vaccine	Yes ( )	No ( )	if yes, please put date: ______________
H1N1 Influenza Vaccine*	Yes ( )	No ( )	if yes, please put date: ______________

______________________________ ______________________________
Physician's Name (Please Print) Physician's Signature

________________ ________________ Physician's Stamp:
Date Phone #

____

____
Physician's Address

I hereby authorize the above name physician to furnish my Health History and Medical Record to the Department of Health Services, Division of EMS and for the Department of Health Services, Division of EMS to furnish a copy of this Health History & Medical Record to any hospital, or other designated clinical site(s) required by my training.

__________________________ __________________________ ______________
Student's Name (Please Print) Student's Signature Date

*If available at the time of the physical.

Health History & Medical Record

The information contained in this Health History & Medical Record may not be used or disclosed unless specifically authorized by the student or is specifically required or permitted by law.

In order to register for an Original AEMT or Paramedic course requiring a Clinical Rotation, this Health History & Medical Record must be completed and be on file with the student's physician.

Name of Student: ______________________________

Student's Address: ______________________________

____

Student's telephone number(s): Day: ____________ Evening: ____________

Name of EMS Agency: ______________________________

Section I – Health History - (To be completed by the student)

Name, telephone number and relationship of person to be notified in case of an emergency: ____________

____

Age: ________ Date of Birth: ____________ Sex: Male: ______ Female: ________

DO YOU HAVE or HAVE YOU HAD:	YES	NO		YES	NO
Alcohol/Drug Dependency	( )	( )	Allergies	( )	( )
Asthma/Respiratory Disorders	( )	( )	Diabetes	( )	( )
Difficulty with Coordination	( )	( )	Emotional Disorder	( )	( )
High Blood Pressure	( )	( )	Heart Disease	( )	( )
Joint Disease	( )	( )	Hepatitis	( )	( )
Rheumatic Fever	( )	( )	Kidney Disease	( )	( )
Seizures, Epilepsy or Loss Of consciousness	( )	( )	Bleeding Disorder	( )	( )
			Ulcer	( )	( )
Vision that cannot be Corrected with glasses	( )	( )	Hernia	( )	( )
			Back Disorders	( )	( )
Other ____________	( )	( )			

Have you been hospitalized within the past five years? Yes ( ) No ( )
Do you take any medications on a regular basis? Yes ( ) No ( )
Have you had the Chickenpox (Varicella)? Yes ( ) No ( )

To the best of my knowledge, the above statements are true.

____________________ ____________________ ____________

Printed Name of Student | Student Signature | Date

Section II - Medical Record

(To be completed by physician) *Please comment on all positive findings.*

Certification of Immunizations:

REQUIRED: Measles (Rubella) Immunity for those born on or after January 1, 1957. Must have one of the following:

1. Approximate date(s) of Measles Immunization (1) _______________ (2) __________________
   The first dose administered on or after the age of 12 months and the second dose administered more than 30 days after the first dose but after 15 months of age.
2. Date of Measles Titer: ____________________ Results: __________________________
3. Approximate date of physician diagnosed measles disease: _________________________

AND signature of the diagnosing physician: ____

REQUIRED: German Measles (Rubella) Immunity – Must have one of the following:

1. Date of at least once Rubella Immunization (1) _________________ (2) _________________
2. Date of Rubella Titer: _____________________ Results: ____________________________

REQUIRED: PPD Mantoux (within six months prior to class; yearly thereafter if negative)

Date of PPD Mantoux: ______________________________
Results: Positive ___________ Negative ____________

If PPD is positive, chest X-ray and record of the results place and date of examination.

____

REQUIRED: Hepatitis B - Satisfy either 1, 2, or 3 below.

1. Three doses of vaccine. First two doses must be thirty days apart and completed before classes begin. Third dose should be given six months after first dose.
   1st Dose Date: _________ 2nd Dose Date: __________ 3rd Dose Date: ___________
2. Titer results showing immunity (attach lab report).
   Date of Titer: _____________ Results: ____

Tetanus: Approximate date of last Tetanus booster: ____________________________________
A Tetanus booster should be given every ten years.

Physical Examination:

Height ________________________ Weight ___________________________
Blood Pressure _________________ Resting Pulse _______________________
Respiratory Rate ________________
Vision: Right 20/ Corrected to: 20/
Left 20/ 20/

Medical Director Endorsement Letter for Advanced Standing

I, ________________________________ the medical director for
(Name)

____________________________________ acknowledge that____________________
(Squad/EMS Agency) (Name of member)

is an active member under my direction and has been so for about________ years. This member is

active on the squad: (please check all that apply)

________ No patient care issues

________ Credentialed for advanced skills

________ Demonstrated the all of the skills checked below

	Administering Nitroglycerin Spray		ECG Monitoring
	Intranasal Medication Administration		Synchronized Cardioversion
	Rectal Diazepam (Valium) Administration		Defibrillation
	Administering Medication by MDI		Transcutaneous Pacing
	ET Drug Administration		12 Lead EKG & Chest Lead Placement
	Withdrawing Medication from an Ampule		Right Chest Lead Placement
	Withdrawing Medication from a Vial		Posterior Chest Lead Placement
	Subcutaneous Injection		Glucometer
	Intramuscular Injection		Normal Delivery with Newborn Care
	Peripheral Venous Access		Abnormal Delivery with Newborn Care
	IV Bolus Medication		Umbilical Vein Cannulation
	IVPB Medication		Care of Amputated Part
	Adult Intraosseous Infusion		Care of an Impaled Object
	Pediatric Intraosseous Infusion		Morgan Lens
	CPAP and PEEP		Rapid Extrication
	Orotracheal Intubation		Standing Takedown
	Pediatric (< 2 Years) Ventilatory Management		Needle Decompression
	Trauma Endotracheal Intubation Adult		Nasotracheal Intubation Adult
	Nasogastric Tube Insertion		Supra-Glottic Aiway Device
	Needle Cricothyrotomy		Surgical Cricothyrotomy
	Upper Airway Suctioning		Flow-Restricted, Oxygen-Powered Ventilation Devices
	Lower Airway Suctioning		Assessment History Medical
	Venturi Mask/Partial Mask		Assessment History Trauma
	Waveform Capnography Management		Assessment and History Pediatric Patient
	Other		

________________________________ ________________
Signature Date

EMS Squad Leader/Chief Endorsement Letter for Advanced Standing

I, _______________________________ the EMS Squad Leader/Chief for
(Name)

____ acknowledge that___________________
(Squad) (Name of member)

is an active member under my squad and has been so for about_______ years. This member is

active on the squad: (please check all that apply)

_______ No patient care issues

_______ Number of ALS Calls completed

_______ Number or hours

_______ Number of BLS calls completed

_______ Number of hours

_______ Demonstrated the all of the skills on the attached list that I have circled.

____ ____________________
Signature Date

CIC/Course Administrator Endorsement Letter for Advanced Standing

I, ______________________________ the representative for
(Name)

____ acknowledge that__________________
(Course Sponsor) (Name of applicant)

Previously participated in an EMS course in________. During the course completed the following

clinical hours:

________ Emergency Department

________ Cardiopulmonary

________ OR

________ OR with minimum 5 intubations

________ Behavioral Health

________ OB

________ Field

Demonstrated in competency in all the circled skills.

____ ____________________
Signature Date