2019 Regional Paramedic Program

Due December 7, 2018

ALSTAR EMS Training Center
335 East Third Street
Jamestown, NY 14701
716-664-8319, Fax: 716-484-8886
estusa2@upmc.edu
Tuition: $4,000 plus book cost (approx $500)

Name

Emergency Contact Phone

Address

Primary EMS Agency

Phone

EMS Level

Email

EMS #

Date of Birth

Expiration date (card must remain valid for duration of course)

Emergency Contact

Years of EMS experience

Primary class location site ◯ Jamestown ◯ Olean

If my choice is full, I would be willing to travel to the other location ◯ Yes ◯ No

I have included the following items with this application:

☐ Copy of my current EMS card

☐ My completed physical and proof of required immunization records

☐ 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. I understand that the course I am applying for is for Paramedic NYS certification only. This does not include NREMT certifications or college credit.

My signature below confirms my acceptance of the above. I understand that 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

Student: _____ EMS Agency: _____

Student DOB: _____ Student Address: _____

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: **In Bold = REQUIRED**
Please see the reverse for specific requirements for proof of documentation.

Measles Date: _____/_____ **Mumps** Date: _____/_____

Rubella Date: _____/_____ or ***MMR*** Date:_____/_____

Td/Tdap Date: _____

Varicella Date: _____/_____
(indicate serology results or provider documented disease date) _____

PPD Negative_____ Positive_____ Date: _____
(past positives require screen for signs/symptoms)

Influenza Vaccine Date: _____

Hepatitis B Date: _____ Date: _____ Date: _____

or **Declination 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 as a paramedic in the paramedic program.
Course Sponsor 03-002

_____ _____ _____
Student's Name (Please Print) **Student's Signature** **Date**

Instructions for acceptable proof of immunity- Check one and attach documents

Measles - Mumps - Rubella Immunity (Required):
A certificate of immunization against measles, mumps and rubella which means:
____ Documentation by physician, physician assistant, or nurse practitioner of two doses of MMR.

~~ OR~~

Mumps Immunity (Required):
A certificate of immunization against mumps which means:

___ A document prepared by a physician, physician assistant, nurse practitioner or a laboratory documenting serologic evidence of mumps (a titer) **or**
___ A document indicating one dose of live virus was administered-1st dose on or after 12 months of age, and 2nd dose more than 30 days after first dose, but after age 15 months **or**
___ A copy of a document from previous employer or school which provides the information described above.

Rubella Immunity (Required):
A certificate of immunization against rubella which means:
___ A document prepared by a physician, physician assistant, nurse practitioner or a laboratory documenting serologic evidence of rubella (a titer) **or**
___ A document indicating one dose of live virus was administered on or after the age of twelve months showing date administered **or**
___ A copy of a document from previous employer or school which provides the information described above.

Measles Immunity (Required):
A certificate of immunization against measles for all persons which means:

___ A document prepared by a physician, physician assistant, nurse practitioner or a laboratory demonstrating serologic evidence of measles antibodies (a titer) **or**
___ A document indicating 2 doses of live measles vaccine were administered - 1st dose on or after 12 months of age, and 2nd dose more than 30 days after first dose, but after age 15 months **or**
___ A copy of a document from previous employer or school which provides the information described above.

Varicella Immunity (Required):
____A certificate of immunization against Varicella – two dose series **or**
____ A document prepared by a physician, physician assistant, nurse practitioner or a laboratory documenting serologic evidence of varicella (a titer) **or**
____Physician documented case of Chickenpox, a copy of a document from previous employer or school which provides the information described above.

PPD (Required)
____PPD (TST-Tuberculin Skin Test) - documentation **REQUIRED** prior to shadow/interning experience

Influenza Vaccine (Required)
____Influenza Vaccine, Documented vaccine or mask wear per facility policy

Additional information

____Hepatitis Series – Highly Recommended but not mandatory ____TDaP - Highly Recommended but not mandatory

Student Health History & Medical Record

Name of Student: _____

Age: _____ Date of Birth: _____ Sex: M F

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 EMS Course requiring a Clinical or Field Rotation, this Health History & Medical Record must be completed and be on file with the student's physician.

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

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	( )	( )	Bleeding Disorder	( )	( )
Of consciousness			Ulcer	( )	( )
Vision that cannot be	( )	( )	Hernia	( )	( )
Corrected with glasses			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, and I am physically able to meet and perform my duties as outlined in the NYS DOH Job Functionality Policy Statement Policy Statement No. 00-10**. I give permission to my course sponsor to release my medical records to any agency or facility at which I am going to participate in clinical or field time during the course of this program.**

_____ _____ _____

Printed Name of Student Student Signature Date