HEALTH SCIENCE PROGRAMS
Chipola College
Marianna, Florida 32446

PARAMEDIC CERTIFICATE PROGRAM

The class meets on Tuesday, Wednesday and Thursday from 12:00 p.m. until 6:00 p.m. The classes will be held at Chipola College Health Science Department. The class is limited to an enrollment of 24 students. Classes will begin on August 23, 2005.

This limited enrollment, competency based program that prepares students for employment as Emergency Medical Service Paramedic and to treat various medical/trauma conditions using appropriate equipment and materials. The program prepares students for certification as EMT-Ps in accordance with Chapter 64E-2 of the Florida Administrative Code. The curriculum encompasses theoretical simulated learning and clinical study in the Revised EMT-P program curriculum and is inclusive of the National Standard Curriculum and Department of Education Curriculum Framework. EMT-P students will adhere to standards as listed in the Chipola College EMT-Paramedic Student Handbook that complies with the DOH-EMS Requirements for Written Rules and Policies. This course is a four (4) semester program. EVOC (Emergency Vehicle Operation Course) training is NOT a part of the course. Clinical assignments are required in addition to regular class hours.

ADMISSIONS REQUIREMENTS:

- Age 18 years or older
- High School Diploma or G.E.D.
- CPT-LPT– minimum score in Reading Comprehension (given at Success Center, bldg O)
- Possess a current Florida EMT-Basic certificate or have applied for and have obtained certification by completion of Phase I. Phase I is equal to the first quarter of class.
- Possess a healthcare provider CPR card.
- Current PPD or chest X-Ray
- Provide FBI Background check (Free from Felony Convictions)
- Completion of application and supporting documentation.
- Successful completion of screening process.

SELECTION CRITERIA:

- Possess a current Florida EMT-Basic certificate or have applied for and obtained certification by the first day of clinical (if out of state licensed).
- Submission of a complete and accurate application for program admission
Background check and physical examination are conducive to state certification and/or employment.

Demonstrated experience in EMS. Minimum 240 hours. (Experience in EMS may be obtained as a volunteer or employee.) The hours must be documented and accompanied by a letter from the EMS supervisor.

3 Letters of recommendation.

Personal interview – Oral interview

Selection Committee selects candidates for program admission based on total points earned in the selection criteria as indicated above.

When selected for a position in the Paramedic Program, the applicant must enter at the designate time or lose his/her position. Positions unclaimed will be given to alternates. Previous selection does not mean automatic selection for a later class, as a new application is required.

If college courses were taken, have an official transcript sent to the Health Science Department and also to the Registrar Office (IF THIS IS THE FIRST TIME ATTENDING CHIPOLA COLLEGE, YOU MUST ALSO APPLY FOR ADMISSIONS TO THE COLLEGE).

As part of the selection process, an interview will be scheduled following the application deadline. Compliance with the above listed prerequisites does not guarantee entry into the EMT-P Program.

*** APPLICATION AND REQUIRED FORMS MUST BE TURNED IN TO THE HEALTH SCIENCE DEPARTMENT NO LATER THAN August 3, 2005. ***

Classes will begin August 23, 2005

Make sure you are CPR certified. This must be done prior to class starting. For more information regarding a CPR class, contact Continuing Education at (850) 718-2297.
CHIPOLA COLLEGE
EMT-PARAMEDIC PROGRAM

STUDENT APPLICATION

Date: __________

1. Name:
   Last                   First                   Middle                   Maiden

2. Completed College Application for Admission __ yes __ no

3. Social Security Number: ___________________________

4. *Florida Resident __ yes __ no       County____________

5. Permanent Home Address: _______________________________________

6. Present Mailing Address: _________________________________________

7. Permanent Phone No. (___)-___-______ Localization No.(___)-___-______

8. Name and location of secondary (high) school from which you graduated:

9. List below all colleges or post-secondary schools you have attended:

<table>
<thead>
<tr>
<th>NAME OF SCHOOL AND ADDRESS ATTENDED</th>
<th>DATES ATTENDED</th>
<th>DEGREES EARNED</th>
<th>REASON FOR LEAVING</th>
<th>CREDITS EARNED</th>
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10. If employed, state briefly your area of work assignment:

    Employer_________________ Position_________________ Phone#______________

11. What is the reason you chose this institution/program over others? __________

    ________________________________________________________________
    __________________________________________________________________
PAST AND PRESENT MEDICAL HISTORY

List childhood diseases you have or have had in the past, if any:

- arthritis
- tuberculosis
- poliomyelitis
- asthma
- rheumatic fever
- malignancies
- jaundice
- epilepsy
- diabetes
- heart problems
- high blood pressure
- communicable diseases
- convulsions
- migraines
- frequent headaches
- back injuries/problems
- knee injuries/problems
- substance abuse/misuse
- hearing impairments
- varicose veins
- hernias

List any operation you have undergone. Include the date of the surgery and the outcome.

Describe any limitation you might feel would impair your ability to function in any capacity as an EMT-P.

VISION: corrected_____ uncorrected_______

Please give a general description of your present health status:

Please list all prescription and over the counter medications you take on a regular basis.
Please describe any food, drug or other allergies you may have:

I certify that the information given in this application is complete and accurate and understand that any misrepresentation of facts may result in immediate dismissal from the EMT-P Program.

_______________________  ________________
Applicant's Signature     Date

**THIS APPLICATION SHOULD BE ACCOMPANIED BY A COPY OF:**

1. EMT-Basic Certification
2. Current CPR card
3. CPT-LPT – minimum score in Reading Comprehension
4. 3 Letters of recommendation.
5. Demonstrated experience in EMS. Minimum 240 hours. (Experience in EMS may be obtained as a volunteer or employee.) The hours must be documented and accompanied by a letter from the EMS supervisor).

PLEASE RETURN THIS APPLICATION TO:

CHIPOLA COLLEGE
HEALTH SCIENCE PROGRAMS
3094 INDIAN CIRCLE
MARIANNA, FLORIDA 32446

For additional information call: (850) 718-2403.
HEALTH CERTIFICATE

All students who are accepted in college’s EMT-P Program are required to submit this Health Certificate by two weeks into the program.

NAME OF APPLICANT:

Last                                               First                               Middle                         Maiden

PRESENT ADDRESS:

Number                     Street                        City               State/Zip                        County

EQUAL OPPORTUNITY DATA  (This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for program admission.)

Sex:   Male ☐ Female ☐   Age: [    ]

Race:    Black ☐ Native American (Indian) ☐ Hispanic ☐ Caucasian ☐ Asian/Pacific Islander ☐

Marital Status:    Single ☐ Married ☐ Widow/er ☐ Divorced ☐

Number of Children: _____ Ages: _____, _____.

Name of person to be notified in case of Emergency:

Address: ______________________ Phone#: __________________Relation: __________________
MEDICAL HISTORY: The following section should be completed by the student and reviewed by a physician or advanced registered nurse practitioner (ARNP). Please list conditions or diseases which you have had or have now. Include the year beside each one and any additional information as needed below the list.

Drug Allergies

Routine Medications

HOSPITALIZATION OR SURGERY

Reason/Date

PAST MEDICAL HISTORY

___Rheumatic Fever          ___Allergies/Hay Fever          ___Gout
___Venereal disease        ___Asthma                  ___Thyroid Disease
___Tuberculosis (TB)       ___Chronic Rashes          ___Bleeding Disorder
___Bronchitis              ___Ulcer                   ___Lung Disease
___Hepatitis              ___GI Disorder             ___Cancer
___Anemia                  ___Gall Bladder Disease    ___Seizures
___Scarlet Fever          ___Prostate Disease        ___Varicose veins
___Heart Disease          ___Bowel Irregularity       ___Back Problems
___High Blood Pressure    ___Sexual/Menstrual Dysfunction ___Arthritis
___Complicated Pregnancy  ___Nervousness             ___Stroke
___Depression              ___Mental Illness          ___Glaucoma
___Diabetes               ___Kidney Disease          ___Tobacco Use
___Frequent Infections    ___Shortness of Breath     ___HIV
___Heart Palpitations     ___Heart Murmur            ___Chest Pain
___Dizziness/Fainting     ___Peripheral vascular disease Other __________

Do you have any physical problems not mentioned above? □ Yes  □ No

___The above statements are true to the best of my knowledge.

Signature/Date

_______________________________

EMT-PARAMEDIC CERTIFICATE PROGRAM
Health Certificate

PHYSICAL EXAM:
To be completed by student's physician or ARNP.

Height______  Weight______  B/P____/____  Pulse Rate_______  Rhythm______

Eyes/Visual

Ears/Auditory

Nose, Throat, Mouth, Neck

Chest

Lungs

Heart

Abdomen

Back/Spine

Extremities

Does the student have any active disease or is any treatment being followed which should be periodically checked? If so, explain:

Is he/she taking any routine medications?  Y  □  N  □

If so, please list type and amount:

Explain:

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Health Certificate
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Please check communicable diseases you have had, vaccines received, and titers and results, include dates for each.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Date</th>
<th>Vaccine</th>
<th>Date</th>
<th>Titer/Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polio</td>
<td></td>
<td></td>
<td></td>
<td>XXXXXXXXXX</td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
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<td>XXXXXXXXXX</td>
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<tr>
<td>Rubella</td>
<td></td>
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<tr>
<td>Rubeola (measles)</td>
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<tr>
<td>Diphtheria</td>
<td></td>
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<td>XXXXXXXXXX</td>
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<tr>
<td>Pertussis</td>
<td></td>
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<td>XXXXXXXXXX</td>
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<td>Tetanus</td>
<td></td>
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<td>XXXXXXXXXX</td>
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<tr>
<td>TB</td>
<td></td>
<td>XXXXXXXXXX</td>
<td></td>
<td>PPD/Reaction</td>
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<tr>
<td>Hepatitis B</td>
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<tr>
<td>Chickenpox</td>
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<td>XXXXXXXXXX</td>
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</tbody>
</table>

Childhood immunizations must be current. If not, you will need measles/rubella vaccine and diphtheria toxoid (DT) or tetanus toxoid. If you have not had chickenpox, you must have a titer done. Hepatitis B titer is required and the vaccine strongly recommended. PPD or chest x-ray must be current (within a year).

This is to certify that I have examined the person named above and that I have found him/her to be in good health and free of communicable disease. Also, in my opinion, this person (IS) (IS NOT) physically able to participate in normal physical education activities. (Please note any abnormalities, physical defects, or diseases which might in any way interfere with the student's attendance and progress in Nursing School as well as known allergies, especially to medications.)

______________________________________________
Signature of Examining Physician or ARNP/Date

______________________________________________
Address

EMT-P Program
Health Certificate
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MEDICAL RELEASE

To be completed by **ALL** students. This **MUST BE** notarized!

I grant permission to the Health Department or the local hospital or medical doctor to render emergency treatment to me that might be deemed necessary.

I understand that I am responsible for any costs incurred and the College is not financially obligated.

____________________________
Signature of student, parent, or guardian
(In ink in the presence of Notary Public)

Sworn to and subscribed to me this ________
day of ________, 20_____

____________________________
Signature of Notary Public

Personally known to me □

Produced __________________________

List hospital insurance company and policy number: