Paramedic Program
NCTI - Springfield
Housatonic Community College Campus

Dear Applicant:

We appreciate your interest in the Springfield Paramedic Program satellite at Housatonic Community College in Bridgeport, CT 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. Applications will be considered on a case-by-case basis if received less than 60 days before the scheduled class date.

The NCTI Springfield 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
Kimberly.arnone@amr.net or (413)846-6155.

Sincerely,

Kimberly D'Angelo
NCTI Program Director

Application Packet
NCTI - Springfield
Housatonic Community College Campus

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 the Lisa Smith.

___ 1. Application, completed and signed.

___ 2. Copy of high school diploma or equivalent or transcript of an Associate or Bachelor degree.

___ 3. Copy of current State or National Registry EMT certification.

___ 4. Copy of current AHA CPR Provider card.

5. Driver's license or government issued ID and either a birth certificate **OR** a copy of valid US Passport.

___ 6. Copies college transcripts.

___ 7. Documentation of completion or enrollment in an approved Anatomy and Physiology course. Completion is required prior to the Paramedic Program start date. If currently enrolled in an A&P course, please specify the program and anticipated date of completion.

___ 8. Record of recent physical exam (within 90 days) on the form provided in the application packet.

___ 9. Proof of completion of the hepatitis vaccination series, MMR, TDaP, meningitis, and chicken pox vaccination – TDaP must have been completed within the last 10 years

___ 10. Complete Pre-Check background check and drug screen.

___ 11. Provide proof of current health insurance.

___ 12. Sign and date the Application Checklist indicating each step has been completed. Mail or scan and email the checklist with your application to **NCTI - Springfield: 595 Cottage St. Springfield, MA 01104 or email to Kimberly.arnone@amr.net**

The student is responsible for making all necessary arrangements to renew certifications that expire during the term of the Paramedic Program.

Signature Date

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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 #:

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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:	Flu:
Meningitis Vaccination:	Physical Exam Form Completed:	EMT Expiration Date:
BLS Expiration:	High School transcript:	Driver's License:
College Transcripts:	Anatomy and Physiology	Proof of Citizenship

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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					

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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

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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

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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	☐	☐	Back problems	☐	☐
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:
_____
_____
_____

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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 of 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

1. 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: _____

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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 _the Program 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.

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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 _____

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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

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Accreditation

The NCTI – Springfield Paramedic 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:

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8301 Lakeview Parkway
Suite 111-312
Rowlett, TX 75088
Phone: 214-703-8445
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www.coaemsp.org