

APPLICATION FOR ADMISSION

Paramedic Program Fall 2009

The Mercy Medical Center Department of EMS Education is pleased to announce that it is now accepting applications for our EMT-Paramedic training program. The Mercy Medical Center EMT-Paramedic program will begin on **Monday, October 5th, 2009**. The course will be held on Monday, and Wednesday evenings from 6:00pm to 10:00pm with an occasional Saturday class from 9am – 5pm. There are also included programs such as Advanced Cardiac Life Support (ACLS) which normally are run during the week from 8am-5pm. Saturday and weekday classes will be announced on day one of the program.

Mercy Medical Center and the department of EMS Education have taken great pride in obtaining the most up-to-date training materials for the most realistic laboratory experience. With the addition of the new state-of-the-art ICU, students will be given the best opportunity to enhance their educational experience during their clinical internship. We have also updated our AV equipment and classroom facilities to create a comfortable learning environment. Classes are being held at the Providence Hospital, 1233 Main Street, Holyoke, MA 01040.

The course will be divided into three educational Didactic Sections (P-I, P-II, and P-III). These Didactic Sections will run from Monday, October 5th, 2009 through October of 2010. Upon successful completion of the Didactic Section, the student will begin the Clinical Internship, which is a minimum 250 hours of clinical interaction with hospital rotations through the ED, CCU, ICU, LDRP (OB), Psychiatric, Pediatrics, and OR. After successful completion of the Clinical Internship, the student will complete the third and final aspect of the program, the Field Internship, by completing a minimum of 250 hours Field Internship with local EMS agencies at the Advanced Life Support level.

The total tuition for the MMC Paramedic Program is \$ 6,000.00. An initial payment of \$3,000.00 is due on day one of the program, October 5th, 2009. The additional \$3,000.00 must be paid in full by the end of the PI didactic section. Payment plans can be made available upon request. You will be provided the Mercy Medical Center Department of EMS Education Tuition Policy & Procedure Manual during your interview. We are currently in the process of applying for the GI Bill. The GI Bill (the generic term comprising various education assistance programs administered by the Department of Veterans Affairs) provides benefits to veterans, servicemembers, and some dependents of disabled or deceased veterans wishing to pursue an education.

Applicants are required to pay a \$30.00 application fee that must be turned in along with the completed application. Applicants will take an entrance exam, complete a CORI Authorization form and meet with the admissions committee prior to beginning the EMT-Paramedic Program. Upon acceptance to the program, each student will be given a syllabus and required textbooks.

APPLICATION FOR ADMISSION

Paramedic Program

Fall 2009

Prerequisites: Currently Certified as an Massachusetts EMT-Basic or Equivalent
Current BLS Healthcare Provider Level CPR Card (AHA or ARC)
Valid Massachusetts Driver's License
High School Diploma, GED, or Equivalent
Up-to-date Immunization record

Full Legal Name: _____
First Middle Initial Last

Permanent Address: _____
Street Address City, State Zip

Phone: _____

E-Mail Address: _____

Employer: _____ Title: _____

Employer Address: _____

Employer Telephone: _____

US Citizen Yes No

Have you been convicted of a felony/misdemeanor (other than traffic offenses)? Yes No

If yes, please explain: _____

ACADEMIC RECORD:

Type of School	Name & Address of School	# Years Completed	Degree Received	Major	Graduated Y/N Date
High School or G.E.D.					
College (Undergraduate)					
College (Graduate)					
EMT Training Program					
Other (Specify)					

APPLICATION FOR ADMISSION
Paramedic Program
Fall 2009

COPIES OF CERTIFICATIONS:

Please Affix a Copy of your Current EMT Card
(*You may include this on a separate page)

Front of EMT Card	Back of EMT Card

Please affix a current copy of your BLS Healthcare Provider CPR Card (AHA or ARC)
(*You may include this on a separate page)

Front of CPR Card	Back of CPR Card

APPLICATION FOR ADMISSION

Paramedic Program

Fall 2009

Please affix a current copy of your Motor Vehicle Driver's License
(*You may include this on a separate page)

Front of Driver's License	Back of Driver's License

For additional information, please contact Robert Chapdelaine, RN, EMT-P Chief Paramedic Program Instructor at (413) 539-2826 or preferably via E-mail EMTP39@aol.com. Upon completion of this application, please mail the application to:

Mercy Medical Center EMS Education
Attn: Robert Chapdelaine, RN, EMT-P
Chief Paramedic Instructor
271 Carew Street
P.O. Box 9012
Springfield, MA 01102-9012

Upon receiving your completed application, you will be contacted to set up an entrance examination and interview. **The deadline to apply for the EMT-Paramedic training program is Monday, August 31st, 2009.** Interviews will be setup for the week of September 7th through the 11th.

Mercy Medical Center, Department of EMS Education does not unlawfully discriminate on the basis of age, race, national origin/ancestry, color, sex, religion/creed, or handicap/disability. Mercy Medical Center, Department of EMS Education Paramedic Program operates in accordance with applicable laws on equal opportunity and non-discrimination in the consideration for admission. **I understand that I must successfully complete the CORI Authorization (Background Check) based on the standards set forth by the Mercy Medical Center.**

I hereby certify that to the best of my knowledge the information furnished on this form is true and complete without evasion or misrepresentation. I understand that if found to be otherwise, it is sufficient cause for rejection and / or dismissal.

APPLICANT'S SIGNATURE: _____ **DATE:** _____

APPLICATION FOR ADMISSION

Paramedic Program Fall 2009

Letters of Reference

Reference #2:

Name: _____
 First Middle Initial Last

Work Address: _____
 Street City, State Zip

Cell Phone: _____ Date: _____

Relation to Applicant: _____ #of Years Known Applicant: _____

E-Mail Address: _____

Reference #3:

Name: _____
 First Middle Initial Last

Work Address: _____
 Street City, State Zip

Cell Phone: _____ Date: _____

Relation to Applicant: _____ #of Years Known Applicant: _____

E-Mail Address: _____

HEALTH REQUIREMENTS FOR PARAMEDIC STUDENTS AT MERCY MEDICAL CENTER

Completed Health Records MUST be submitted to MMC EMS Education Department prior to Program admission.

The MMC Paramedic Program Health Requirements are as follows:

- **P E** - Physical Exam within a year of starting the program
- **Tetanus** - diphtheria within the past ten (10) years
- **Measles** – two (2) doses at least one month apart or positive titer
- **Mumps** – one (1) dose or positive titer
- **Rubella** – one (1) dose or positive titer
- **Varicella** – positive titer or two (2) vaccine doses, at least one month apart
- **TB Screen** – PPD (Mantoux) test – if positive, chest x-ray is required.
(For those who have not had a Tuberculosis Screening test in the last year, two tests, two weeks apart are required.)
- **Hep B*** - Hepatitis B two (2) doses one month apart, 3rd dose six (6) months after the first, or positive titer.

* At least two (2) doses of Hepatitis B are required to enter the program

**MERCY MEDICAL CENTER
PARAMEDIC PROGRAM**

PART A IMMUNIZATION RECORD

NAME: _____
First
Middle Initial
Last
Suffix

IMMUNIZATION	DATE GIVEN (mm / dd / yy)	REQUIREMENTS
Tetanus-Diphtheria (Td)	_____	Within past ten (10) years
Measles Vaccine #1 or MMR Vaccine #1 or Positive Measles antibody (IgG)	_____ _____ _____	Must be on or after date of first birthday, and must be after 01 / 01 / 68
Measles Vaccine #2 or MMR Vaccine #2	_____ _____	Must be at least one (1) month after the first dose (28 days)
Mumps Vaccine or Positive Mumps antibody (IgG)	_____ _____	Must be on or after date of first birthday, and must be after 01 / 01 / 68 *Copy of lab report required
Rubella Vaccine or Positive Rubella antibody (IgG)	_____ _____	Must be on or after date of first birthday, and must be after 01 / 01 / 68 *Copy of lab report required

<p>Hepatitis B Vaccine #1 and Hepatitis Vaccine #2 and Hepatitis Vaccine #3 or Positive Hepatitis B surface antibody</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Hepatitis B Vaccine Recommended schedule: Dose #1: _____ Dose #2: _____ *one month after first Dose #3: _____ *six months after first *Copy of lab report required</p>
<p>Varicella Vaccine #1 and Varicella Vaccine #2 or Positive Varicella antibody</p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>*Copy of lab report required *If blood test is negative, two (2) doses of vaccine are required to provide immunity.</p>

SIGNATURE OF HEALTH CARE PROVIDER

SIGNATURE

DATE

PRINTED NAME

ADDRESS: _____

PHONE: _____

FAX: _____

**MERCY MEDICAL CENTER
PARAMEDIC PROGRAM
HEALTH REQUIREMENTS**

PART B HEALTH HISTORY

(To be filled out by the student)

Please complete and bring for review with health care provider conducting physical exam.

Please mark if you answer “YES” to ever having any of the following:

- | | | |
|---------------------------------------------------------------|-------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> heart disease / condition | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> cancer |
| <input type="checkbox"/> seizure disorder | <input type="checkbox"/> dizziness | <input type="checkbox"/> vision problems |
| <input type="checkbox"/> hearing loss | <input type="checkbox"/> frequent headaches | <input type="checkbox"/> asthma |
| <input type="checkbox"/> kidney problems | <input type="checkbox"/> hernia | <input type="checkbox"/> mental illness |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> diabetes | <input type="checkbox"/> skin disease |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> repeated fainting |
| <input type="checkbox"/> frequent cough | <input type="checkbox"/> frequent diarrhea | <input type="checkbox"/> hospitalization |
| <input type="checkbox"/> frequent abdominal pain | <input type="checkbox"/> surgery | <input type="checkbox"/> latex allergy |
| <input type="checkbox"/> unexplained weight loss | <input type="checkbox"/> varicose veins | <input type="checkbox"/> numbness in hands |
| <input type="checkbox"/> drug / alcohol dependency | <input type="checkbox"/> back injury / problems | <input type="checkbox"/> pneumonia |
| <input type="checkbox"/> exposure to / positive testing to TB | | |
| <input type="checkbox"/> other _____ | | |

Limited or painful movement of use of:

- | | | | | |
|---------------------------------|--------------------------------------|-----------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> neck | <input type="checkbox"/> shoulder(s) | <input type="checkbox"/> elbow(s) | <input type="checkbox"/> wrist(s) | <input type="checkbox"/> hand(s) |
| <input type="checkbox"/> hip(s) | <input type="checkbox"/> knee(s) | <input type="checkbox"/> ankle(s) | <input type="checkbox"/> feet | <input type="checkbox"/> back |

Please explain for any “YES” answers: _____

List all current MEDICATIONS you take: _____

Please list all ALLERGIES (foods, Rx, latex, etc...): _____

Have you been given work restrictions within the past five (5) years?

Yes No If "Yes" please explain:

Do you have any condition which may require adaptation of your educational / clinical program? (i.e. special needs)

Yes No If "Yes" please explain:

PART C STUDENT STATEMENT

- ✓ I recognize that all health information received by the EMS Education Department is confidential and will not be released without my written consent.
- ✓ I agree to notify the EMS Education Department with any changes in my health status.
- ✓ I understand that failure to comply with the required health records / immunizations by the mandatory deadlines will result in exemption from the program. I fully understand it is my responsibility as the student to provide all required documentation prior to the start of the program.
- ✓ I verify that all of the above health history information is correct and up to date to the best of my knowledge.

Student's Signature

Date

PART D RELEASE OF INFORMATION

I, _____ hereby grant Mercy Medical Center, Department of
(Print Student Name)

EMS Education permission to release information regarding immunizations, immunity to infectious diseases, Tuberculosis screening results, allergies (including latex allergies) and treatments to the EMS Coordinator, Clinical and Field agencies (i.e. hospitals, long-term care facilities, EMS agencies) for my paramedic placements.

Student's Signature

Date

**MERCY MEDICAL CENTER
PARAMEDIC PROGRAM
HEALTH REQUIREMENTS**

PART E PHYSICAL EXAMINATION

(To be completed by a physician, physician's assistant or nurse practitioner herein known as Health Care Provider.)

1. Please review Part B of the Health Requirements Packet for completeness and provide any additional history / comments: (This information is strictly confidential and will only be released with written consent of the student.) _____

2. Students enrolled in the MMC Paramedic Program must display proficiency in a variety of skills and movements. Students must meet minimum standards. Students must be capable of performing tasks such as lifting, bending, hand / eye / foot coordination, verbal and auditory perception, and possess the ability to communicate with other health care professionals. The physical exam should consist of tests to verify the students' abilities.

3. PHYSICAL EXAMINATION

Date of Exam: _____

Student information:

Age: _____ D.O.B.: _____

Height: _____ Weight: _____ lbs.

BP: _____ Pulse: _____ RR: _____

Vision: R _____ L _____ Corrective Lens: ___Y___N

Body Systems Examination

S = Satisfactory A = Abnormal

		Musculoskeletal	
Skin / scars	S / A	Hands	S / A
HEENT	S / A	Wrists	S / A
Neck	S / A	Arms	S / A
Lymph nodes	S / A	Shoulders	S / A
Thorax / Lungs	S / A	Hips	S / A
Heart	S / A	Knees	S / A
Abdomen	S / A	Ankles	S / A
Peripheral Vascular	S / A	Feet	S / A
Neurological	S / A	Spine	S / A
Mental Status	S / A	Other:	_____

Please explain any abnormal findings or add additional comments: _____

Do you believe this applicant is capable of performing all necessary tasks involved with the MMC Paramedic Program?

Yes **No** **If "Yes" please explain:** _____

Are there any other evaluations / testing the applicant requires prior to entering the program?

Yes **No** **If "Yes" please explain:** _____

(If yes, results may be mailed to Robert Chapdelaine, Chief Paramedic Instructor, 271 Carew Street, Springfield, MA, 01102)

SIGNATURE OF HEALTH CARE PROVIDER

SIGNATURE

DATE

Please Print Name

**MERCY MEDICAL CENTER
PARAMEDIC PROGRAM
TUBERCULIN SKIN TEST FORM
(PPD / MANTOUX)**

Name: _____				
First	Middle	Last	Suffix	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female				
Address: _____				
Street			Apt.	

City,		State	Zip	
Phone: _____				

REASON FOR TESTING: _____

Occupation: _____ **Private Physician:** _____

Address: _____

No.	Street	City,	State	Zip
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Previous TB Test: _____

Date	Location	Result
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Previous Chest X-Ray: _____

Date	Location	Result
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Known Chest Condition: _____
(Hereby request the Mantoux TB skin test, with a chest X-ray also if test is positive)

Student Signature

Date

PATIENT RECORD

Date: _____

X-Ray Number: _____

Date: _____

YOUR MANTOUX TEST WAS:

CHEST X-RAY SATISFACTORY

NEGATIVE _____mm

__ YES __ NO

POSITIVE _____mm

*Copy of CXR required if positive

Preventive TB Therapy:

__ YES __ NO

Medication: _____

Start Date: _____

Completion Date: _____

This will certify that the person named is free from tuberculosis in communicable form.

Health Care Provider: _____

Signature

Date

Address: _____

No.

Street

City,

State

Zip

Telephone: _____