



# New Haven Sponsor Hospital Paramedic Program APPLICATION

**Program being applied for :** Day Program Evening Program

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**Start Date** \_\_\_\_\_

## Demographics

Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
First Middle Last

Home Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Cell Number \_\_\_\_\_

Driver's License # \_\_\_\_\_ Expiration Date \_\_\_\_\_

EMT Certification # \_\_\_\_\_ Level of Cert \_\_\_\_\_ Exp. Date \_\_\_\_\_ State \_\_\_\_\_

Number of Years in EMS at any level \_\_\_\_\_

## Current or Primary EMS Employer

Organization Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Position : \_\_\_\_\_ Date Employed(from) \_\_\_\_\_ (to) \_\_\_\_\_

Duties: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Contact number \_\_\_\_\_

I hereby confirm that the above listed information is accurate and truthful.

Supervisor's Signature: \_\_\_\_\_ Printed Name \_\_\_\_\_ Date: \_\_\_\_\_

## Current other or secondary EMS Employer/Service

Organization Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Position: \_\_\_\_\_ Date Employed(from) \_\_\_\_\_ (to) \_\_\_\_\_

Duties: \_\_\_\_\_

Supervisor: \_\_\_\_\_



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## Past EMS Employment or Volunteer Membership

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Please include ALL PRIOR EMS affiliations beginning with the most recent.  
Attach separate sheet if necessary.

1. Organization Name \_\_\_\_\_ Telephone # \_\_\_\_\_  
Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Position: \_\_\_\_\_ Date Employed \_\_\_\_\_  
Duties: \_\_\_\_\_  
Supervisor: \_\_\_\_\_

2. Organization Name \_\_\_\_\_ Telephone # \_\_\_\_\_  
Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Position: \_\_\_\_\_ Date Employed \_\_\_\_\_  
Duties: \_\_\_\_\_  
Supervisor: \_\_\_\_\_

3. Organization Name \_\_\_\_\_ Telephone # \_\_\_\_\_  
Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Position: \_\_\_\_\_ Date Employed \_\_\_\_\_  
Duties: \_\_\_\_\_  
Supervisor: \_\_\_\_\_

### Non- EMS Employment

Organization Name \_\_\_\_\_ Telephone # \_\_\_\_\_  
Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Position: \_\_\_\_\_ Date Employed \_\_\_\_\_  
Duties: \_\_\_\_\_  
Supervisor: \_\_\_\_\_



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## EDUCATION

### COLLEGE

College \_\_\_\_\_

Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Degree completed : \_\_\_\_\_ Date Attended (month/year) \_\_\_\_\_

If no degree, courses attended: \_\_\_\_\_

### HIGH SCHOOL:

High School Attended: \_\_\_\_\_

Diploma/GED: \_\_\_\_\_ Date \_\_\_\_\_

Please attach a list additional post secondary schools if attended. Please enclose photocopy of diploma(s) received and have official transcript(s) sent directly to NHSHP for any education listed above.

Do you have a diagnosed learning disability? Yes \_\_\_\_\_ No \_\_\_\_\_

If "YES", attach documentation in an envelope **sealed and marked** "Confidential".

### Military Service

Branch: \_\_\_\_\_

Dates of Service, From: \_\_\_\_\_ To \_\_\_\_\_

Months/Duties: \_\_\_\_\_

Current Status: \_\_\_\_\_

Type of Discharge: \_\_\_\_\_

Attach a listing of all continuing medical education and other certifications taken or held.

**Please enclose a one page type written essay on what you believe will be the future of Paramedicine**

Have you had any felony or criminal convictions other than traffic violations within the last five years?

Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, attach a signed note of explanation in an envelope **sealed and marked** "Confidential".

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I attest that all information in this application is correct and truthful. I understand that discovery of falsification of the above is full and sufficient reason for dismissal from the program. I have read the program description and information.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date





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## HEALTH INSURANCE WAIVER

I, \_\_\_\_\_, understand that in the course of my paramedic training, I may have an increased risk of exposure to hazardous situations and/or infectious diseases. I agree to maintain personal health insurance during my training and understand that the New Haven Sponsor Hospital Program will not provide such coverage. Furthermore, the New Haven Sponsor Hospital Program and its clinical affiliates and Internship sites will not provide Worker's Compensation insurance to students for training related illnesses or injuries.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Date



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## SUBSTANCE ABUSE FORM

To Whom It May Concern:

I certify that I am not actively addicted to alcohol or other drugs. I certify that I have no substance abuse or alcohol problems and that I do not use illegal drugs. I understand that discovery of such addiction or use may be reason for dismissal from the program.

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Applicant Signature

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Date

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Notary Public

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Date



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## HEPATITIS B FORM

I have been advised by the New Haven Sponsor Hospital program that I should be vaccinated against Hepatitis B, and if I decline, I understand I will likely be exposed to hepatitis B and other infectious diseases and that contracting the illness may have serious consequences, including that of death. I further understand that failure to have various up to date vaccinations and provide proof to the same, may preclude me from participating in clinical experiences and field internship necessary for successful graduation.

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Applicant Signature

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Date

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Notary Public

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Date



# **New Haven Sponsor Hospital Paramedic Program APPLICATION**

## **IMMUNIZATION RECORDS**

The New Haven Sponsor Hospital Program, to be consistent with Public Act 89-90 effective July 1, 1989, will require anyone born after 12/31/56 to provide proof of immunization for Measles, Rubella, Mumps, Polio, Tetanus/Diphtheria within five years and a Mantoux Skin test for tuberculosis within six months. Each candidate must show documentation of one of the following:

1. Proof of Age, if born after 1956
2. Proof of vaccination via titer
3. Proof of Disease by Physician's Certificate

It is also strongly suggested that each student be immunized against Hepatitis B. If immunized, please provide documentation of Hepatitis B vaccination. Failure to have various up to date vaccinations and provide proof to the same, may preclude you from participating in clinical experiences and field internship necessary for successful graduation.