



New Haven Sponsor Hospital Paramedic Program APPLICATION

Application for: Sept 2009_____ or January 2010_____

Demographics **Please Type or Print Clearly**

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 State # _____ Level of Cert _____ Exp. Date _____

Nationally Registered _____ Exp Date _____ NR# _____

Number of Years in EMS at any level _____

What professional organizations (such as NAEMT) do you belong to?

Current or Primary EMS Employer

Organization Name _____ Telephone # _____

Address _____ City/Town _____ State _____ Zip _____

Position _____ Date Employed _____

Duties (Emergency response or transfer) _____ Approx. # of calls providing direct pt care _____

Supervisor _____

Current Secondary EMS Employer/Service

Organization Name _____ Telephone # _____

Address _____ City/Town _____ State _____ Zip _____

Position _____ Date Employed _____ to _____

Duties (Emergency response or transfer) _____ Approx. # of calls providing direct pt care: _____

Supervisor _____

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Past EMS Employment or Volunteer Membership

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 _____ to _____
Duties (Emergency response or Transfer) _____ Approx. # of calls providing direct pt care _____
Supervisor _____

2. Organization Name _____ Telephone # _____
Address _____ City/Town _____ State _____ Zip _____
Position _____ Date Employed _____ to _____
Duties (Emergency response or Transfer) _____ Approx. # of calls providing direct pt care _____
Supervisor _____

3. Organization Name _____ Telephone # _____
Address _____ City/Town _____ State _____ Zip _____
Position _____ Date Employed _____ to _____
Duties (Emergency response or Transfer) _____ Approx. # of calls providing direct pt care _____
Supervisor _____

Non-EMS prior Employment

Please include **ALL PRIOR** Non-EMS employment beginning with the most recent.
Attach separate sheet if necessary.

Organization Name _____ Telephone # _____
Address _____ City/Town _____ State _____ Zip _____
Position _____ Date Employed _____ to _____
Duties _____
Supervisor _____

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EDUCATION

COLLEGE:

College _____

Address _____ City/Town _____ State _____ Zip _____

Degree & Concentration _____ Date Attended month/year _____

If no degree, courses attended _____

If more than one attach the same information on separate page.

HIGH SCHOOL:

High School Attended _____

Diploma/GED _____ Date _____

Please attach copy of diplomas and transcripts for any schools attended.

Do you have a diagnosed learning disability or need any special educational accommodations?

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 _____



Have you had any felony or criminal convictions? Yes _____ No _____

Has your right to practice as an EMT ever been revoked or restricted? Yes _____ No _____

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

I attest and certify that all information in this application is correct and truthful. I understand that any misrepresentation or omission on this application or any supporting documents will be grounds for dismissal from the program.

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 and its clinical sites will not provide such coverage. I agree to submit proof of immunizations and screening examinations as required. I further understand some clinical rotations necessary for successful completion may be denied to me if I do not have personal health insurance or proof of immunizations. Furthermore, the New Haven Sponsor Hospital Program or its clinical sites will not provide Worker's Compensation insurance to students for training related illnesses or injuries.

Applicant Signature

Date

Notary Public

Date

I, _____ am physically and mentally fit and able to carry out the duties of a Paramedic as described in the technical standards and am free of known communicable diseases.

Applicant Signature

Date

Notary Public

Date

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SUBSTANCE ABUSE FORM

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 also understand that New Haven Sponsor Hospital Program may request drug testing from me at any time during my matriculation with the Program. I further understand a positive drug test is grounds for dismissal from the program.

Applicant Signature

Date

Notary Public

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 may potentially be exposed in the course of this program and that contracting the illness may have serious consequences, including that of death. I understand some or all clinical opportunities necessary for successful graduation may be denied to me if I do not have or maintain up to date vaccinations including Hepatitis B, MMR, DPT, and a negative PPD within the year.

Applicant Signature

Date

Notary Public

Date

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IMMUNIZATION RECORDS

The New Haven Sponsor Hospital Program, to be consistent with Public Act 89-90 effective July 1, 1989, and in compliance with clinical site contracts, 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 PPD Skin test for tuberculosis within six months. Each candidate must provide 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. Due to hospital regulations some or all clinical affiliations necessary to successfully complete the program and graduate may be denied to any student who does not supply up to date proof of the above immunizations and tests.

I have read, understand and agree to comply with the above:

Signed _____ Date _____

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References: Three letters of reference are required; one from each of the following categories. Please provide a copy of the reference letter form (included) to the person providing your letter and ask them to mail it directly to the program. Letters should be placed in a sealed envelope and signed across the seal by the party completing the form. Reference letters other than those in signed, sealed envelopes will not be accepted.

- A) Emergency Department Physician (MD or DO) or Physician Assistant (PA),
- B) EMS Supervisor
- C) Peer in the EMS field.

Please list the contact information for the people submitting references on your behalf.

A). ED Physician or PA _____

Address _____

B). EMS Supervisor _____

Address _____

C). EMS Peer _____

Address _____

Candidate essay: On a separate piece of paper please answer the following question in a single typed page of least 250 words.

“What do you see as the future of Emergency Medical Services and how will you contribute to it”

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Application Check List

Have you included?

- A completed application form with attachments
- A \$25 application fee payable to New Haven Sponsor Hospital Program
- A typewritten essay (approximately one page in length)
- Copy of your current certifications, including front and back of CPR card, EMT and driver's licenses.
- Copies of high school or college diplomas and official transcripts
- Proof of vaccinations: MMR, DPT, Hep B and PPD
- A signed release for each employer and school attended
- A signed substance abuse form
- A signed health insurance waiver
- List of address for references:
 - Emergency Department Physician or PA
 - EMS Supervisor
 - EMS colleague
- Have you talked with them? Have they mailed your reference letter?

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