



## Paramedic Program Livermore

### **Dear Applicant:**

We appreciate your interest in the NCTI Livermore Paramedic Program 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 you have selected. Applications will be considered on a case-by-case basis if received less than 60 days before the scheduled class date.

The NCTI Livermore 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 [Lisa.Smith@amr.net](mailto:Lisa.Smith@amr.net) or (916) 960-6286.

Sincerely,

Lisa Smith  
Student Registration Coordinator



# Application Packet Livermore

## 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 Lisa Smith.

- 1. Application, completed and signed.
  - 2. Copy of high school diploma or equivalent or official transcript of an Associate or Bachelor degree.
  - 3. Copy of current State or County EMT card.
  - 4. Copy of current AHA BLS Provider card.
  - 5. Driver's license / government issued ID and Birth certificate OR a copy of valid US Passport.
  - 6. Copies of college official transcripts, if applicable.
  - 7. Documentation of completion or enrollment in an approved Anatomy and Physiology course (3 credit hours). Completion is required prior to the Paramedic Program start date. Provide a copy of official transcripts. If currently enrolled in an A&P course, please specify the program and anticipated date of completion.
  - 8. Record of recent physical exam (within 6 months) on the form provided in the application packet. Medical examiner is not accepted.
  - 9. Proof of completion of the hepatitis vaccination series, MMR, Hep B, T-dap, meningitis, and chicken pox vaccination – T-Dap must have been completed within the last 10 years, TB, flu for season
  - 10. Provide proof of current health insurance.
  - 11. Sign and date the Application Checklist indicating each step has been completed. Mail or scan and email the checklist with your application and required document copies to the **NCTI Business Office: Email: [Lisa.Smith@AMR.net](mailto:Lisa.Smith@AMR.net) or Mail to NCTI 2995 Foothills Blvd Ste 100 Roseville, CA 95747**
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The student is responsible for making all necessary arrangements to renew certifications that expire during the term of the Paramedic Program.

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Signature

Date



## Application Packet Livermore

**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: 1.            2.
T-dap Vaccination:	TB Test:	Flu:
Meningitis Vaccination:	Physical Exam Form Completed:	EMT/NREMT 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.

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Name

Signature

Date



# Application Packet Livermore

## 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	<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>
Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>	GI disease/ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disorder/treatment	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease/gall bladder	<input type="checkbox"/>	<input type="checkbox"/>
Received a transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Chest x-ray – date of last one	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Knee problems	<input type="checkbox"/>	<input type="checkbox"/>
Neck problems	<input type="checkbox"/>	<input type="checkbox"/>	Foot problems	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder problems	<input type="checkbox"/>	<input type="checkbox"/>	Skin problems or dermatitis	<input type="checkbox"/>	<input type="checkbox"/>
Tendinitis/carpal tunnel/upper extremity problem	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Lung problems/asthma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
High/Low Thyroid	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

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)*	<input type="checkbox"/>	<input type="checkbox"/>	Rubella (German Measles) vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Rubeola (Measles)*	<input type="checkbox"/>	<input type="checkbox"/>	Measles (Rubeola) vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Chicken pox (Varicella)*	<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox (Varicella) vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Mumps vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis – other than Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B vaccine - List Dates:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Mumps*	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus shot - List Date:	<input type="checkbox"/>	<input type="checkbox"/>
Strep infection	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above, please explain:

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\* 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	<input type="checkbox"/>	<input type="checkbox"/>	Smoke	<input type="checkbox"/>	<input type="checkbox"/>
Fumes	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus toxoid	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal pollen/grasses/molds	<input type="checkbox"/>	<input type="checkbox"/>	Latex sensitive	<input type="checkbox"/>	<input type="checkbox"/>
Medications/sensitive	<input type="checkbox"/>	<input type="checkbox"/>	Chemicals/sensitive	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above, please explain:

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List any medications you have taken in the past 3 months:

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## Occupational Work History

- 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?	<input type="checkbox"/>	<input type="checkbox"/>	Any permanent disability or impairment?	<input type="checkbox"/>	<input type="checkbox"/>
Exposed to excessive noise? (machines, shooting)	<input type="checkbox"/>	<input type="checkbox"/>	Exposed to chemicals at work?	<input type="checkbox"/>	<input type="checkbox"/>
Worn film badge?	<input type="checkbox"/>	<input type="checkbox"/>	Ever worn hearing protection?	<input type="checkbox"/>	<input type="checkbox"/>
Had an overexposure to ethylene oxide?	<input type="checkbox"/>	<input type="checkbox"/>	Worked with ethylene oxide?	<input type="checkbox"/>	<input type="checkbox"/>
Exposed to heavy metals, carcinogens, and lasers?	<input type="checkbox"/>	<input type="checkbox"/>	Worked with formaldehyde?	<input type="checkbox"/>	<input type="checkbox"/>

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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**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: \_\_\_\_\_

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Signature (MD/DO completing physical) & Credentials

Name (please print)

Date



## Application Packet Livermore

### Accreditation

The 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](http://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](http://www.coaemsp.org) or contacting the executive office at:

#### **CoAEMSP**

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Suite 111-312  
Rowlett, TX 75088  
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Fax: 214-703-8992  
[www.coaemsp.org](http://www.coaemsp.org)