PARAMEDIC PROGRAM APPLICATION PROCESS

The Emergency Medical Technology Department at Columbus State Community College accepts applications for their Paramedic Program year round.

Class times are as follows:

**Daytime Program schedule:**
- Tues and Thurs Lecture 8:00 – Noon
- Tues or Thurs Hosp. Clinical 13:00 – 17:00
- Wed Lab 8:00 – 12:00

**Afternoon Program schedule:**
- Tues and Thurs Lecture 13:00 - 17:00
- Hosp. Clinical Tues or Thur 08:00 - 12:00
- Lab: Wed 13:00 – 17:00

**Evening Program schedule:**
- Tues & Thur 17:00 - 21:00
- Hospital Clinical Mon or Wed 17:00 - 21:00
- Lab: Mon or Wed 17:00 - 21:00

**Mandatory Field Clinical requirement for all students to be determined by faculty.**

Below are the requirements for this *competitive program:*

- Be a certified EMT in the State of Ohio.
- Completion of the Columbus State Paramedic Prep Course (EMS 1002) with a minimum grade of 75%.
- Completion of the HESI (A2) exam within the past 12 months OR completion of the FISDAP Paramedic Entrance Exam.**
- A letter of recommendation written by your EMT instructor or your immediate supervisor at your place of employment.
- Complete and submit the attached Paramedic Program application
- Applications must be hand delivered to an EMS staff member in a sealed envelope, a receipt will be provided.

If you have any questions please contact 614-287-3812 or email ems@cscc.edu.

*We accept 24 students into each of our classes. This is a competitive process. Students are awarded points based on the following criteria: HESI (A2) exam/FISDAP score, previous college course work, relevant patient care experience, and current ALS affiliation.

**FISDAP Paramedic Entrance Exam will be given during EMS 1002 Paramedic Prep Course or by appt only. Students with applications will be notified of the date, time and location. You will need to bring a credit card with you to pay the $24.00 fee for the test.
When you place your initial order, you will be prompted to create your secure CertifiedProfile account. From within your CertifiedProfile, you will be able to:

- ✔ View your order results
- ✔ Manage the requirements specific to your program
- ✔ Complete tasks as directed to meet deadlines
- ✔ Upload and store important documents and records
- ✔ Place additional orders as needed

To place your order, go to [www.certifiedprofile.com](http://www.certifiedprofile.com)

In the “Place Order” field, enter the following package code specific to your school and program:

During order placement you will be asked for personal identifying information needed for security or compliance purposes. Supplying accurate and comprehensive information is important to the speed in which your order is completed.

The email address you use when placing your order will become your username for your CertifiedProfile and will be the primary form of communication for alerts and messages. Payment methods include: MasterCard, Visa, debit card, electronic check, money order, and installment payment.

You can respond to any active alerts or To-Do List items now, or return later by logging into your CertifiedProfile. You will receive alerts if information is needed to process your order. Access your CertifiedProfile anytime to view order status and completed results. Authorized users at your school will have access to view your compliance status from a separate CertifiedBackground portal.
PARAMEDIC PROGRAM APPLICATION

Which session are you applying for? Please rank in order of preference.

☐ Morning  ☐ Afternoon  ☐ Evening  ☐ Part – Time (5 semester program)  ☐ First Available

Applicant Information

Cougar ID: ____________________________

Full Name: __________________________________________ Date: ________________

Last                   First                   M.I.

Address: __________________________________________________________

Street Address __________________________ Apartment/Unit # ________________

City __________________________ State __________ ZIP Code __________

Home Phone: __________________________ Cell Phone: __________________________

CSCC Email Address: __________________________ Personal Email Address: __________________________

Ohio EMT Certification Number: ____________ Expiration Date: ____________

National Registry Number: ____________ Expiration Date: ____________

Have you ever had an EMT or health care certificate of any type revoked in any state? YES ☐ NO ☐ If yes, when and where? __________________________

Have you ever been enrolled in a paramedic program YES ☐ NO ☐ If yes, when and where? __________________________

Do you feel that you are physically fit, of good moral character, and motivated to serve independently as a Paramedic YES ☐ NO ☐

Essay

Tell us why you think you would make a great paramedic, use an additional sheet if necessary.
### Previous Patient Care Experience

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<tr>
<th>Company:</th>
<th>ALS Provider:</th>
<th>Address:</th>
<th>Supervisor:</th>
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<tr>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<th>Job Title:</th>
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<th>Reason for Leaving:</th>
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May we contact your previous supervisor for a reference? YES NO

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I have read and understand all of the preceding questions and statements contained in this document. I understand that CSCC may conduct an investigation into my background to obtain information on my character, general personal characteristics, and criminal record, if any. I hereby authorize CSCC or its representatives to investigate information, statements and/or references provided in this application, without liability arising therefore. I have read understand and agree to all above said statements. By signing this form I am declaring that I have answered all questions truthfully and to the best of my ability.

Print Name: ____________________________________________

Signature: ____________________________________________ Date: __________________
HEALTH HISTORY
To be completed by the Student:

PLEASE PRINT ALL INFORMATION                        COUGAR I.D. ____________

Name: ____________________________ SS#: ____________________________

Last First Middle
Address: ____________________________

City State Zip
Date of Birth: ____________, Phone: ____________________________

Month/Day/Year Home Other
Program of Study: ____________________________

Semester to Begin Program: ____________________________ E-mail: ____________________________

INSTRUCTIONS FOR COMPLETION OF HEALTH RECORD
1. Please read and follow all instructions so we can process your records as quickly and accurately as possible. If you do not follow instructions or do not submit complete information, processing of your health record might be delayed, which might delay your ability to register into your courses. All information must be completed before you will be eligible to register.

2. Answer all questions. If the answer is “no, none, not applicable”, write that as your answer. Make certain you have entered your program of study above so we will know which requirements apply to you.

   If you have had a physical examination within the past year you can submit that documentation rather than have another physical at this time IF all of our needed information is on your documentation.

3. It is your responsibility, not your physician’s, to make certain that all health requirements have been completed and documentation of all items is submitted to the college. Please verify that you have the appropriate documents prior to submitting them to the college.

4. Remember to make photocopies of this record for your own file prior to submitting your documents to the Health Records Office.

5. Allow up to five business days to process your health records. Records are processed in the order in which they are received. If your health records are submitted less than five business days prior to the beginning of the registration period, we cannot guarantee that we can process them before the first day of registration.

6. Submit completed health record to: Columbus State Community College, Health Records Office, Union Hall Room 132, 550 East Spring Street, Columbus OH 43215; or fax to 614-287-5386, including current name and Cougar ID on all faxed pages. You may also email your Health Record to healthrecords@csc.edu. Emails will only be accepted from your student email account (@student.cscc.edu) QUESTIONS?? Call 614-287-2450
Do you have a sensitivity or allergy to latex? No _____ Yes _____
If yes you will need to complete the “Latex Reaction Form” which can be accessed from the college’s web site at http://cscc.edu/Students/FormsPDF/health/LatexReactionForm.pdf. Print the form, complete your portion, and then give the form to your physician to complete his or her portion. Your completed Latex Reaction Form must be submitted with the rest of your health record forms.

List all allergies and sensitivities you have including medications, food, & environmental:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

List all surgical operations you have had with the date:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

List all current health conditions you have:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

List any previous significant health problems you have had:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The information you are reporting to Columbus State Community College is used to provide health information required by the college’s clinical affiliates, and to verify your ability to perform essential functions of the clinical tasks safely.

It is the policy of Columbus State Community College not to discriminate against any individual. This assurance of non-discrimination includes applicants for academic admission, and shall be applied regardless of race, color, gender, age, religion, ancestry, national origin, disability, or veteran status.

I certify that the health information I have given is accurate and complete. I understand that providing false information on this document is a serious offense which will result in disciplinary action. I understand that if my health, physical condition, or physical abilities change during my enrollment in a health-related program at Columbus State Community College I must report these changes to my program coordinator and to the Health Records Office. I understand that physical exam and tuberculin testing results may be released to clinical sites prior to my clinical/practicum experiences. I understand that conditions which may affect my ability to perform essential functions of the clinical tasks or which may affect my ability to function with safety for myself and/or others might be discussed with my department chair or program coordinator.

________________________________________________________________________
Student Signature                               Date
COLUMBUS STATE COMMUNITY COLLEGE HEALTH RECORD

**Physical Examination:** Must be performed by Physician, Nurse Practitioner or Physician’s Assistant

Name: ___________________________________________  SS#: __________________________

Last  First  Middle

Allergies: ____________________________________________

Medications: ____________________________________________

Height: __________  Weight: __________  Pulse: __________  B/P: __________________________

EXAMINER: Indicate your findings after examination of each system

**EENT:** ____________________________________________

**NEURO:** ____________________________________________

**CV:** ____________________________________________

**RESP:** ____________________________________________

**ENDOCRINE:** ____________________________________________

**MUSC/SKEL:** ____________________________________________

☐ If this student has any reaction to latex, please complete the Examiner’s portion of the “Latex Reactions Form” that the student will supply to you.

☐ If this student is subject to any health emergency, please provide special emergency instructions below.

☐ If there is additional significant information about this student which would relate to his or her safety for patients or for self in a clinical or laboratory situation, please provide information below.

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Does student have any functional limitations or restrictions that would prevent him/her from working in a patient care area?

| Vision, such as reading gauges or monitors? | Yes | No |
| Hearing, such as in a classroom or when using a stethoscope? | | |
| Speech, such as in a classroom or while assessing patients? | | |
| Ability to lift and carry up to 50 pounds? | | |
| Walking/Standing/Kneeling on floor/ground for periods of time while performing skills? | | |
| Ability to move an average size adult? | | |
| Sensorimotor (fine and gross)? | | |
| Emotionally stable to deal with stressful situations? | | |

Does the student have any limitations or restrictions? If no, please document below “No restrictions/No limitations”. If yes, please provide specific facts regarding student’s requirements.

________________________________________________________________________

Examiner’s Signature: ____________________________________________

Print Examiner’s Name: ____________________________________________

Address: ____________________________________________

Phone: __________________  Date: __________________
COLUMBUS STATE COMMUNITY COLLEGE HEALTH RECORD

Tuberculosis Testing

Name: ________________________________

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<tr>
<td>Tb#1</td>
<td>Tb#2 At least 7 days after the first Tb test:</td>
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<tr>
<td>Date given: ___________</td>
<td>Date given: ___________</td>
</tr>
<tr>
<td>Date read: ___________</td>
<td>Date read: ___________</td>
</tr>
<tr>
<td>Result: ___________ mm</td>
<td>Result: ___________ mm</td>
</tr>
<tr>
<td>Read by: __________________</td>
<td>Read by: __________________</td>
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If this test or a previous test is positive: Submit documentation of positive PPD and a negative chest x-ray report from within the past five years. If your previous chest x-ray or positive PPD has been more than a year ago, please complete an Annual Health Evaluation form found at http://cscc.edu/Students/FormsPDF/health/Annual.pdf.

Facility Name: ________________________________
Address: ________________________________
Phone: __________________ Date: __________________

Submit completed health record to: Columbus State Community College, Health Records Office, Union Hall Room 132, 550 East Spring Street, Columbus OH 43215; or fax to 614-287-5386, including current name and Cougar ID on all faxed pages. You may also email your Health Record to healthrecords@csecc.edu. Emails will only be accepted from your student email account (@student.cscc.edu) QUESTIONS?? Call 614-287-2450
COLUMBUS STATE COMMUNITY COLLEGE
SUPPLEMENTARY IMMUNIZATION RECORD

NAME ______________________________ SS# ______________________________

PROGRAM __________________________ COUGAR ID# ______________________

TO BE COMPLETED BY THE PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT

THE FOLLOWING IMMUNIZATIONS ARE REQUIRED:

1. Hepatitis B: Dates of Hepatitis B immunization: #1 ________________, #2 ________________, #3 ________________ (Must have immunizations #1 and #2 completed before submitting health record and final immunization completed on schedule.)

OR

Date and results of hepatitis B surface antibody

NOTE: If the surface antibody is negative, the student must receive the immunization series.

2. MMR: Date of first immunization _______________ Date of second _______________

OR

Date and results of Rubeola IGG titer _______________. Mumps IGG titer _______________.

Date and results of Rubella IGG titer _________________.

NOTE: If titer is negative, the student must receive the immunization series.

DO NOT RECEIVE MMR IMMUNIZATION WHILE YOU ARE COMPLETING THE TWO-STEP TUBERCULOSIS TEST. The measles component invalidates the tuberculosis test, so you would have to repeat the tuberculosis testing which may delay your ability to register into your program.

3. Chickenpox/Varicella: Date of first immunization ____________ Date of second ____________

Both immunizations required before submitting health record.

OR

Date and results of varicella IGG titer

HISTORY OF DISEASE/ILLNESS IS NOT ACCEPTABLE DOCUMENTATION!

DO NOT RECEIVE THE VARICELLA IMMUNIZATIONS WHILE YOU ARE COMPLETING THE TWO-STEP TUBERCULOSIS TEST.

4. Tdap: (Tetanus and Whooping Cough): Date of immunization within past 8 year’s ________________

5. Flu Vaccine: _______________________(CURRENT SEASONAL FLU REQUIRED)

Signature: __________________________________________________________

Printed Name and Title: ______________________________________________

Organization: ________________________________________________________

Phone: ______________________ Date: ______________________