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:**
- Tue, Wed, Thurs: 8 to 12n
- Hospital CL: Tue, Wed, Thur: 1 to 5p
- Field CL: Flexible Schedule

**Afternoon Program schedule:**
- Tue, Wed, Thurs: 12:00 – 16:00
- Hospital CL: Mon 9 to 5, Tue, Wed, Thur: 5 to 9
- Field CL: Flexible Schedule

**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 FISDAP Paramedic Entrance Exam** within the past 12 months.
- 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 should be hand delivered to an EMS staff member in a sealed envelope. The date and time the application is received will be documented on the application.
- Copies of your State of Ohio EMT card, IS 100, and IS 700 certificates must be submitted with the application.

If you have any questions please contact 614-287-2812 or email khicks2@csc.edu

*We accept 24 students into each of our classes. This is a competitive process. Students are awarded points based of the following criteria: 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 fee for the test. (Approximate Cost $25.00)**

All applications are to be submitted by Friday July 19, 2019 for consideration into the August 2019 Paramedic Program.
Emergency Medical Services Program

FINGERPRINT AND DRUG SCREEN

Before Starting:

- A valid email is REQUIRED
  (if you do not have an email account you can establish a free account at Yahoo.com)

- You must be near a printer to print forms.
- Please review your authorization form closely, as you will have a limited amount of time to complete your drug test.

Getting Started:

1. Have your credit card/debit card (Visa/MasterCard/American Express/Discover) information ready in order to process payment. Your credit card will be charged $112.25 for the service.

2. Log onto our website at www.VerifyStudents.com

3. Use this special promotional code: COLU8435

4. Complete profile & e-sign forms as they appear

5. Print Fingerprint Control Form (sample form shown below on left)

6. Schedule your drug test
   a. Print the authorization form (sample form shown below on the right) or
   b. Check your email and click the link to show the form on your smartphone

After completing online process:

1. Drug testing: go to collection site listed on authorization form
   - Be prepared to show the authorization form & government photo ID, e.g. – driver’s

2. Fingerprinting
   - Bring Fingerprint Control Form & government photo ID, e.g. – driver’s license to your school’s designated fingerprint location:

Columbus-Fast Fingerprints
1486 Bethel Road (Inside Bethel Centre)
Columbus, Ohio 43220
(877) 932-2435
**Hours:** 8:00am-5:00pm Monday-Friday, 9:00am-12:00pm Saturday. WALK-INS WELCOME!

**All network fingerprint site locations and hours are subject to change without notice.**

NOTE: A unique login will be emailed to you. This will allow you to log back into www.VerifyStudents.com
PARAMEDIC PROGRAM APPLICATION PROCESS

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

☐ Morning ☐ Afternoon ☐ First Available

<table>
<thead>
<tr>
<th>Applicant Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cougar ID: ____________________________</td>
</tr>
<tr>
<td>Full Name: ____________________________ Date: ____________</td>
</tr>
<tr>
<td>Last</td>
</tr>
<tr>
<td>Address: __________________________________________</td>
</tr>
<tr>
<td>Street Address</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>Home Phone: ____________________________ Cell Phone: ____________________________</td>
</tr>
<tr>
<td>CSCC Email Address: ____________________________ Personal Email Address: ____________________________</td>
</tr>
<tr>
<td>Ohio EMT Certification Number: ____________ Expiration Date: ____________</td>
</tr>
<tr>
<td>National Registry Number: ____________ Expiration Date: ____________</td>
</tr>
<tr>
<td>Completion of IS 100 Date: ____________ Completion of IS 700 Date: ____________</td>
</tr>
</tbody>
</table>

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?  
Yes: ☐ No: ☐

Do you feel that you are physically fit, of good moral character, and motivated to serve independently as a paramedic?  
Yes: ☐ No: ☐

If yes, when and where? ____________________________

Date Rec’d: ________ Time Rec’d: ________ Initials: ________
Tell us why you think you would make a great paramedic, use an additional sheet if necessary.
| Company: | ALS Provider: □ Yes □ No |
| Address: | Supervisor: |
| Job Title: | Phone: |
| From: | To: |
| Reason for Leaving: |

May we contact your previous supervisor for a reference? □ YES □ NO

| Company: | ALS Provider: □ Yes □ No |
| Address: | Supervisor: |
| Job Title: | Phone: |
| From: | To: |
| Reason for Leaving: |

May we contact your previous supervisor for a reference? □ YES □ NO

| Company: | ALS Provider: □ Yes □ No |
| Address: | Supervisor: |
| Job Title: | Phone: |
| From: | To: |
| Reason for Leaving: |

May we contact your previous supervisor for a reference? □ YES □ NO

4/24/2019 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 therefrom. 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: ________________________________
START YOUR CAREER IN EMS AS AN EMERGENCY MEDICAL TECHNICIAN (EMT) WITH AN EMS SCHOLARSHIP

- 20 Scholarships Available
- Scholarships cover cost of credit hours for EMT class (excludes books, lab fees, etc)
- Upon completion, EMT’s will have immediate full time employment at Med- Care with benefits including:
  - Health, vision, dental insurance and immediate PTO accrual
  - 403b retirement package
  - National Registry Refresher and other continuing education provided on site
- Scholarships will be awarded on a first come first serve for those who apply, pass screening process, and agree to terms of scholarship.

To Apply:
- AQUIRE AN EMS SCHOLARSHIP APPLICATION AVAILABLE ONLINE AT WWW.MEDCAREOHIO.ORG OR PICK UP A PAPER COPY AT COLUMBUS STATE OR ANY MEDCARE STATION

MedCare Ambulance
3699 Paragon Drive
Columbus, Ohio 43228
614-751-6651
ACCREDITED

Columbus State
Emergency Medical Technology
375 North Grant Avenue
Columbus, Ohio 43215
614-287-5353

Visit: www.medcareohio.org

Applying for scholarships at Columbus State now takes just a single application.

Now, applying for scholarships at Columbus State is as easy as visiting cscc.edu/scholarships and completing one scholarship application. When you submit your scholarship application, Columbus State will:

- Review your scholarship application and match you with all Columbus State scholarships for which you meet the criteria.
- Forward your scholarship application to appropriate scholarship review committees.
- Alert you if additional information is needed for specific scholarships.
- Notify you of scholarships that you have been rewarded!

Visit cscc.edu/scholarships today to fill out your scholarship application early. Many scholarships have limited funds and are awarded to the first qualified applicants.
**Why We Use Academic Works**

- Easier for student and financial aid office
- Cut down on many man hours and resources
- 1 time portal login. Student enters cougar id and it populates all of students general information
- Students will complete a general application that will automatically apply them for all standard scholarships
- Software will identify other scholarship opportunities based on their general information and allow students to take additional steps to apply for others.
- System will allow for students to apply for all eligible scholarships (now they can only apply for up to 4)
- Allows us to have a longer offering time frame
- Ease of review for those reviewing scholarships. Reviewers will be given a temporary login/password to get into system to review and score applications as needed
- Allows us to monitor scholarship funds more readily
- We can contact students via email through Academic Works to make award offers, allow students to accept and submit thank you letters. Notify students that didn’t receive award.
- Allows for private recommendation letters to be submitted from outside sources
- Will allow for more scholarship offerings if needed.
- Provides a central location for all institutional and external scholarship opportunities.
- **Much quicker** turnaround time on scholarship recipient selection

**Besides the basic Scholarships and Financial Aid opportunities, EMS specific students may be able to apply for the following two Scholarships.**

---

**John M. McCormac Memorial Scholarship in Emergency Medical Services**

**CRITERIA**

Have passed the pretest and been accepted into Columbus State’s Para-medical Certification Program. The recipient must be a first semester para-medical class applicant.

Maintain a minimum 3.0 GPA in the paramedic program during the time he or she is receiving the scholarship.

If your employer reimburses you greater than 75%, you are not eligible for this scholarship. Please submit a letter from your employer which verifies their tuition reimbursement policy.

Financial need may be considered.

Submit a one page personal statement addressing your academic/career goals and the potential impact of receiving this scholarship.

Submit a letter of recommendation from an employer or EMS Instructor.

Submit a resume.

**Eligible Majors**

- EMS Fire ATS
- EMS AAS (Paramedic Major)
- Paramedic Certificate

**Award Amounts**

$1000.00*

*Payment is distributed in equal amounts over three semesters. In example, a student who receives a $1000.00 scholarship will receive $334.00 the first semester and then $333.00 each of the two subsequent semesters as long as they maintain a 3.0 GPA.
COLUMBUS STATE COMMUNITY COLLEGE
Paramedic

HEALTH HISTORY
To be completed by the Student:

PLEASE PRINT ALL INFORMATION COUGAR I.D. ____________

Name: __________________________ SS#: ____________
Last First Middle
Address: __________________________ City __________________ State Zip
Street __________________________
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 website 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.

<table>
<thead>
<tr>
<th>Does student have any functional limitations or restrictions that would prevent him/her from working in a patient care area?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision, such as reading gauges or monitors?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing, such as in a classroom or when using a stethoscope?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech, such as in a classroom or while assessing patients?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to lift and carry up to 50 pounds?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking/Standing/Kneeling on floor/ground for periods of time while performing skills?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to move an average size adult?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensorimotor (fine and gross)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotionally stable to deal with stressful situations?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:______________________________

Revised 8-29-18
COLUMBUS STATE COMMUNITY COLLEGE HEALTH RECORD

Tuberculosis Testing

Name: _________________________________

<table>
<thead>
<tr>
<th>Tuberculosis Testing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Two-Step Mantoux</strong> (intradermal) is required. This involves two Tb Mantoux tests at least 7 days apart and within the last year. Two or three days after each Tb test is given it must be read by the physician, nurse, or physician’s assistant. Tb tine tests are not acceptable per state regulations. Two Mantoux tests within the past year can be substituted per state regulations. If the student recently received an MMR or varicella vaccine, the tuberculosis test must be postponed until at least four to six weeks after the MMR.</td>
<td></td>
</tr>
<tr>
<td><strong>Tb#1</strong></td>
<td><strong>Tb#2 At least 7 days after the first Tb test:</strong></td>
</tr>
<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>
</tr>
</tbody>
</table>

**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](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@cscc.edu. Emails will only be accepted from your student email account (@student.cscc.edu) QUESTIONS?? Call 614-287-2450

Revised 8-29-18
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: __________________

Revised 8-29-18