

**EMS Programs**

**EMS Program Coordinators**

**149 SE College Place**

**Lake City, FL 32025**

EMS Program Candidates:

Students who have been conditionally accepted into any EMS program of study that requires participation in a hands-on clinical rotation in the community setting must complete this eligibility packet**.** These tasks include the completion of a criminal background screening, at least a 9‑panel drug screening, a physical exam including a PPD skin test, and official documentation of immunization for measles, mumps, rubella, chickenpox, hepatitis B, and tetanus. Students must also submit copies of documentation demonstrating proof of completion (color copy of the front and back of the signed card) or enrollment in a course for Healthcare Provider BLS training, and color copies of the front and back of your driver’s license and health insurance card. **Some type of health insurance is required for acceptance into the program.**

These requirements are placed on the college by the clinical sites through a contractual agreement. All hospitals wishing to maintain their Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) accreditation have been instructed to treat students in their facilities the same as they do employees. Therefore, we have no choice but to comply with this request.

Attached is a detailed list of the information you must provide ***prior to being registered*** for the EMT or Paramedic courses. Please use the accompanying checklist and forms to complete this process. ***All information is due to the program coordinator prior to attending the mandatory orientation held before each semester begins. The program coordinator may accept completed applications up until the last day of drop/add as determined by the Florida Gateway College Critical Dates Calendar.* Students who have not complied with this request will be automatically withdrawn from their program**.

All documentation should be submitted, in a manila folder or envelope as an **all-inclusive packet**. This will eliminate the possibility of specific pieces of the documentation being misplaced or separated from the application packet. All documentation must be current and must remain valid throughout the entire program of study.

**All costs associated with these requirements are the responsibility of the student**.

**Carefully read the information provided and keep it in a safe place for future reference**.

**Note: Once documentation is submitted to the college, it becomes the property of the college. Copies of this documentation will not be provided back to the student at any future date. Keep your original certifications for your professional records.**

**DETAILED INFORMATION ON**

**EXPERIENTIAL (CLINICAL) ELIGIBILITY DOCUMENTATION**

**BACKGROUND CHECK and DRUG SCREEN:** Each student will complete a background check and drug screen through the college-approved screening service, Certified Background.

**Background Check:**

EMS students at Florida Gateway College involved in direct patient care during a clinical rotation in a hospital or healthcare facility or with a pre-hospital agency are required to complete an in-depth background check. This is a requirement mandated under the guidelines cited in Florida Statute 435 and by healthcare agencies with which FGC has clinical, internship, and externship agreements.

Any student who has been arrested, regardless of adjudication, plea of *nolo contendere*, or plea of guilty to any offense under the provisions of Florida Statutes or under a similar statute of another jurisdiction, may be disqualified from admission.

**Drug Screen:**

Prior to enrolling in the EMT or Paramedic courses, students must be tested and must pass a drug screening. The drug screening must satisfactorily demonstrate that the student is free from the use of any illegal drug and un-prescribed controlled substance described or named in the law hereinafter referred to as “drug-free”. Applicants must be tested by urinalysis for **at least** the following classes: amphetamines, cannabinoids (marijuana), cocaine, opiates, and phencyclidine (PCP). Random screenings within the program may be required. This test must be completed through Castlebranch with the Program Code that will be provided by the EMS Programs Coordinator.

All students enrolled in any health program are required to be drug and/or alcohol-free when at the college and while at any “affiliating agency” (including parking lots and grounds). “Affiliating agencies” may require students to be subject to the agencies’ drug testing policies, including but not limited to, when there is reasonable suspicion to believe a student may be impaired, or is using or has used illegal drugs and/or alcohol. The student may be tested in accordance with the “affiliating agency’s” policies. If tested by an “affiliating agency”, the student shall provide his/her program coordinator with a copy of any test results. Failure to promptly do so shall be grounds for dismissal from the program and/or college.

A positive drug or alcohol test shall also be grounds for dismissal from the program. Admitted students must remain drug-free throughout the tenure in their program at the college. Failure to do so shall be grounds for dismissal from the program.

**HEALTH STATUS DOCUMENTATION:** Submit appropriate current physical and immunization records.

**Recent Physical:** Examination is to be completed by a licensed doctor, physician’s assistant, nurse practitioner, or mid-wife. *Physicals should be completed no more than six months prior to beginning the program.*

**Tuberculosis Screening:** A current *(within past six months)* TB skin test (PPD) is required. A new chest x-ray not more than three months old is necessary if you cannot have a PPD done. Any waiver for a TB skin test from a healthcare provider must be on professional letterhead.

**Tetanus:** If tetanus booster is greater than 10 years old, it is required that a booster be obtained.

**Proof of Immunity:** Use of the Academy of Allied Health Proof of Immunity form is required. Proof of Immunity must be submitted from **official documentation only**. Official medical records from your doctor, the health department, or public school are acceptable. If official documentation is not available, then blood titers are necessary to determine immunity for:

* Hepatitis B (3 doses or titer)
* Varicella, aka chicken pox (2 doses or titer)
* Measles, Mumps and Rubella (2 dose combination or titer)

Vaccinations may be necessary if immunity cannot be confirmed with the blood titer.

**Hepatitis B:** If a hepatitis B vaccine is required, the series of three immunizations must be started ASAP and may be completed during the clinical rotation. A titer at six months after completion of the series is recommended to document immunity. This can be declined on the attached form, but it immunization is strongly encouraged.

**Flu Vaccination:** It is the responsibility of all students to obtain flu vaccinations if attending clinical rotations during the fall or spring semesters. Securing the vaccinations is the responsibility of the student.

**CPR CERTIFICATION:** Submit proof of current training in Healthcare Provider CPR. Acceptable CPR courses include: BLS Provider from American Heart Association (AHA) courses or Professional Rescuer for American Red Cross (ARC) courses. This documentation is earned during HCP 0001 or WFHX 0003. No other CPR courses will be accepted. All other students must provide a copy of current CPR card to the Program Coordinator(s). All students are responsible for remaining current in CPR and for submitting documentation of updates to the Program Coordinator(s).

**PROOF OF INSURANCE:** Submit proof of health/hospitalization insurance to the Program Coordinator (color copy front and back of card). This insurance must be effective throughout the internship/clinical rotations.

**DRIVER’S LICENSE:** Submit a color copy of the front and back of your current driver’s license.

**Check List (you will not be registered for the course without a complete packet):**

\_\_ Acceptance to the College \_\_ NFSI (EMT) \_\_\_ PERT if necessary (Paramedic)

\_\_ EMS Program Application \_\_ Current BLS card (or registered for a class)

\_\_ Resume \_\_ Health Insurance (color copy of the front and back)

\_\_ Cover Letter \_\_ Driver’s License (color copy)

\_\_ Current Physical \_\_ Receipt from Cashier (for drug screen and fingerprints)

\_\_ Current PPD \_\_ Finger Prints done at Olustee Campus

\_\_ Immunizations \_\_ Castlebranch registration and drug screen completed

\_\_ Flu Vaccine

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST. ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First MI

***HEPATITIS B VACCINE STATEMENT***

Because of the possibility of exposure to patients infected with Hepatitis B, it is highly recommended that a student enrolled in any health program receive the Hepatitis B vaccine which includes a series of three injections. *Students must obtain a titer six months after completion of the series to document immunity.* **If you have had this vaccine or are in the process of completing the series, a shot record must be provided from your health care provider documenting the dates the shots were/are being received.**  
  
To satisfy the agreements with the healthcare facilities in which you will be practicing, please indicate your Hepatitis B vaccination status by selecting one of the statements below:

1.\_\_\_\_\_I AM IN THE PROCESS OF TAKING THE HEPATITIS B VACCINE SERIES

**(Attach shot record)**

Initial Vaccination: Date: / /

2nd Series Vaccination: Date: / /

3rd Series Vaccination: Date: / /

2.\_\_\_\_\_I HAVE COMPLETED THE HEPATITIS B VACCINE SERIES

**(Attach shot record)**

Initial Vaccination: Date: / /

2nd Series Vaccination: Date: / /

3rd Series Vaccination: Date: / /

**\*All students who have completed vaccine series must provide documentation of adequate titer levels.** Titers must be obtained 6 months or more following the 3rd vaccine.

\_\_\_\_\_\_ Hepatitis B Titer: Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Immune Not Immune

(Circle one)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT Student Name SIGN Student Name

Date:

3.\_\_\_\_\_ I DO NOT WISH TO TAKE THE HEPATITIS B VACCINE OR TITER

PRINT Student Name SIGN Student Name

Date:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST. ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First MI

# TO BE COMPLETED BY STUDENT:

# PHYSICAL EXAMINATION FORM

# A physical exam within six month prior to beginning the program is important to ensure that students enrolled in an Academy of Allied Health program can meet the demands of their profession without hazard to themselves or others.

# 1. Medical History: (Check all that apply.)

The student has a history of:

* + Alcoholism
  + Allergies (including drugs)
  + Asthma
  + COPD
  + Diabetes Mellitus
  + Drug Addiction
  + GI Disorder
  + Headaches (frequent / migraine)
  + Heart Disease
  + Hernia
  + Immune Disorder
  + Psychiatric History
  + Seizure Disorders
  + Smoking
  + Substance / Alcohol Abuse
  + Thyroid Disorder
  + Tuberculosis
  + Unexplained Syncope
  + Weak Back / Back Surgery
  + Hearing Impairments
  + Motor Impairments
  + Visual Impairment

Current history:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current Medication List:

Medication: Reason:

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NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ST.ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First MI

**TO BE COMPLETED BY PHYSICIAN:**

**2. Physical Examination:** Date of birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

General Appearance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_

Male \_\_\_\_ Female\_\_\_\_(check one) Pregnant? Yes: \_\_\_\_\_ No: \_\_\_\_\_

T/P/R: \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ B/P: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chest \_\_\_\_\_ Heart \_\_\_\_\_ Lungs \_\_\_\_\_ GI/GU \_\_\_\_\_ Musculoskeletal \_\_\_\_\_

Neurologic \_\_\_\_\_

Ears \_\_\_\_\_ Hearing: rt \_\_\_\_\_lft \_\_\_\_\_ Eyes \_\_\_\_\_ Vision: rt \_\_\_\_\_lft \_\_\_\_\_

Colorblind \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Latex Allergy: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Drug Allergy: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any weight lifting limitations? Yes: \_\_\_\_\_ No: \_\_\_\_\_ Specify limits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. LAB TESTS**: **PPD: \_\_\_\_/\_\_\_\_/\_\_\_\_ Results: \_\_\_\_/\_\_\_\_/\_\_\_\_Induration: \_\_\_\_\_\_\_\_\_\_**

**(Date given) (Date read)**

**If positive or contraindicated, date of last chest x-ray and/or proof of annual questionnaire:**

**\_\_\_\_\_\_\_ x-ray Date: \_\_\_\_/\_\_\_\_/\_\_\_\_**

**\_\_\_\_\_\_\_ Questionnaire on file Date: \_\_\_\_/\_\_\_\_/\_\_\_\_**

Do you consider this applicant physically and emotionally stable to work as a healthcare professional?

Yes \_\_\_\_\_ No \_\_\_\_\_ **If no, please attach an explanation.**

In your opinion, is there any reason that the applicant should NOT participate in the clinical activities related to the students program of study? Yes \_\_\_\_ No \_\_\_\_ **If yes, please attach an explanation.**

Licensed as (circle one): MD DO PA ARNP CMW

Health Care Provider: (Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed:

(Signature of Health Care Provider) (Phone) (Date)