



BASIC EMT

State Accreditation #329
(740) 389-4681 ext. 110

Course Description: This 130 hour program (114 classroom and 10 clinical, 6 hours National Registry exam) follows the U.S. D.O.T. and Ohio Division of EMS guidelines. Certification as an Ohio EMT is contingent upon successfully completing the course requirements and passing the National Registry Practical and Written Exam.

ELIGIBILITY REQUIREMENTS of State and School

1. Must be 18 years of age to sit for National Registry exam
2. Must have a high school diploma or GED (submit copy) with application
3. Successful completion of Work Keys Reading exam at level 4
4. Current AHA Healthcare Provider CPR card or American Red Cross CPR for the Professional Rescuer Card.

Fall Basic EMT Class

September – December

Monday & Wednesday 5:30 pm – 9:30 pm
1 Saturday Each Month 8:00 am – 4:00 pm

Winter Basic EMT class

January - May

Monday & Wednesday 5:30 pm – 9:30 pm
1 Saturday Each Month 8:00am – 4:00pm

Summer Accelerated Basic EMT class

June & July

Monday & Wednesday 8:00 am – 3:30 pm
Tuesday & Thursday 8:00 am – 12:00 pm

COSTS:

- \$ 50 application fee** (Non-Refundable)
- \$ 79 CPR** (if needed, includes book and pocket mask)
- \$745 tuition*** (includes shirt, lab fees, exam fee, stethoscope.)
- \$101.88 Books**

The student may be required to meet **additional pre-requisites**, depending on the clinical site chosen. This may include, but not be limited to: **varicella titer, rubella titer, mantoux 2 step test**. If required by the clinical site, these additional costs will be the STUDENT'S RESPONSIBILITY. The school strongly recommends that the students should consider completing the series of inoculation for **Hepatitis B virus**.

OTHER COSTS (estimated)

Hepatitis B Vaccine (recommended)	32.00 – 40.00
Mantoux 2 Step Test (TB test)	12.00 – 15.00
Rubella	7.00 – 39.00
Varicella Titer	35.00 – 50.00
Watch w/second hand	30.00
Paper Supplies	40.00

Immunizations may be done at:

Marion Co. Health Dept., 98 McKinley Park Dr., Marion, on Mondays 8:30 – 11:30 and 1:00 – 4:00 or
Occupational Health, 1050 Delaware Avenue, Marion, M, T, W, F, 8:00 – 12:00 or 1:00 – 5:00 or
Contact your physician.

*Unless a double payment has inadvertently been made, no refund will be issued to a student without the student first submitting a request in writing to the director explaining the extenuating circumstances and proof wherever possible. Any refunds that are ultimately issued may take two weeks to process. **Cost subject to change.***

01/29/07 ry



**TRI-RIVERS/MARION GENERAL HOSPITAL
SCHOOL OF PARAMEDICINE
ODPS Accreditation #329**

**EMT BASIC
Application Form**

An official high school transcript or GED MUST accompany this application or it will not be accepted.

Name _____ S.S.# _____
First Last Maiden

Are any of your educational or employment records in another name/s? If so, identify:

Address _____ City _____

State _____ Zip Code _____ County _____

Telephone (_____) _____ (_____) _____
Home Work

Mobile Phone # (_____) _____ E-mail address _____

Follow-up Contact Person (Relative/Friend/Neighbor)

_____ (_____) _____
Name Telephone

U.S. Citizen ___ Yes ___ Eligible Non-Citizen Alien # _____
(Documentation needed)

***Have you attended Tri-Rivers Adult Ed. before? Yes No

If yes, what program? _____ Year _____

Check all levels of education you have achieved:

___ No Diploma Highest grade completed _____

___ GED* Date successfully completed _____

___ High School Diploma School _____

City, State _____ Graduation Date _____

___ Technical Certificate/ Associate Degree School _____

Major _____ Yr. Comp. _____

___ Bachelor's Degree School _____

Major _____ Yr. Comp. _____

___ Other School _____

Major _____ Yr. Comp. _____

List any certificates or licenses you hold:

<u>Certificates/licenses</u>	<u>Expiration Date</u>	<u>Certificates/licenses</u>	<u>Expiration Date</u>
_____	_____	_____	_____
_____	_____	_____	_____

List present or last employer first. Include volunteer work.

Dates From/To	Company	Address, City, State	Job Title	Supervisor's Name

Military Experience:

Are you presently affiliated with an EMS? _____ Yes _____ No

If yes, what service do you work for? _____

What is your position with this service? _____

How long have you been with this service? _____ How long have you been an EMT-B? _____

List any other EMS you are working for or have worked for: _____

Do you have any other health related work experience? _____

1. Have you ever been convicted of, pled guilty to, or had a judicial finding of guilt for any of the following: fraud or material deception in applying for, or obtaining a certificate to practice; any of the following felonies: murder, aggravated murder, voluntary manslaughter, felonious assault, kidnapping, rape, sexual battery, gross sexual imposition, aggravated arson, aggravated robbery, aggravated burglary; a misdemeanor, other than a traffic violation committed in the course of practice, a misdemeanor involving moral turpitude; a violation of any federal, state, county or municipal narcotics law; any act committed in another state, that, if committed in Ohio, would constitute a violation set forth in 4765-8-01 (A) (3) (b) of the Ohio Administrative Code: _____ Yes _____ No
2. Have you been adjudicated mentally incompetent by a court of law? _____ Yes _____ No
3. Are you currently under indictment for a felony or misdemeanor involving moral turpitude? _____ Yes _____ No
4. Do you currently engage in the illegal use of controlled substances, alcohol, or other habit-forming drugs or chemical substances? _____ Yes _____ No

**** If you answered yes to any of the above, please attach documentation to explain ****

I certify that the information contained in this application and all information, which I have forwarded to or given Tri-Rivers/Marion General Hospital School of Paramedicine in support of my application is correct, and I understand that misrepresentation, falsification or omission of material fact may be cause for rejection of my application or termination after acceptance. I understand and agree that statements made in this application may be subject to verification as the school may contact past employers and other individuals for reference. I hereby release any such person and company from any and all liability of whatsoever nature because of furnishing such information.

I consent to the release of information contained in my application and school record files, as it pertains to the selection and education processes of Tri-Rivers/Marion General Hospital School of Paramedicine, to employees of Tri-Rivers, Marion General Hospital or members of the advisory committee of the school. The program director shall control the release of such information in this manner.

A \$95.00 non-refundable application fee is required upon submitting the application form. The application will not be considered until the fee is paid in full and the high school transcript or GED is received.

Signature

Date

Tri-Rivers Public Safety Services Training Program

MEDICAL HISTORY

TO BE FILLED OUT BY CANDIDATE

Name _____ Address _____

Telephone (____) _____

Date of Birth _____ Male _____ Female _____ Occupation _____

Family Physician _____ Telephone (____) _____

History: Please read carefully, and check if you have EVER had the following (to be completed by the applicant):

	YES	NO
1. Convulsion or fainting spells	_____	_____
2. Skin trouble.	_____	_____
3. Any broken bones.	_____	_____
4. Nervous disorder.	_____	_____
5. Eye trouble or hearing problems.	_____	_____
6. Varicose veins or leg sores.	_____	_____
7. Lead or chrome poisoning.	_____	_____
8. Miscarriages.	_____	_____
9. Is there any family history of tuberculosis or diabetes?	_____	_____
10. Any physical defects?	_____	_____
11. Have you received compensation for occupational disease or injury?	_____	_____
12. Have you been in the service?	_____	_____
13. Were you medically discharged or rejected from the service?	_____	_____
14. Have you missed time for painful or difficult menstrual periods?	_____	_____

Circle and give the approximate year, if you have had any of the following conditions:

- | | | |
|---------------------|----------------------|---------------------------|
| Allergies | Anemia | Arthritis |
| Asthma | Back Trouble | Bronchitis |
| Cancer | Diabetes | Diphtheria |
| Eczema | Epilepsy | Frequent Colds |
| Frequent Diarrhea | Gallbladder Trouble | Goiter |
| Gonorrhea | Hay fever | Heart Disease |
| Hemorrhoids | Hepatitis | Hernia |
| High Blood Pressure | Indigestion (severe) | Kidney or Bladder Trouble |
| Malaria | Migraine | Mononucleosis |
| Pleurisy | Pneumonia | Poliomyelitis |
| Rheumatic Fever | Rheumatism | Scarlet Fever |
| Silicosis | Syphilis | Tonsillitis |
| Tuberculosis | Ulcer | |

Have you ever been injured? _____ Type _____ When _____

Have you ever been Hospitalized? _____ Type _____ When _____

Have you ever had any operations? _____ Type _____ When _____

Have you ever been in a private or public institution for mental illness? If so, give particulars. _____

Recent illness (within past two years) _____

Are you pregnant? _____

Have you had any medical problems not covered in the previous questions? If so, state: _____

Additional Information. _____

I hereby certify that the above answers are true. I also understand that good physical and emotional health, as judged by a medical doctor, are factors in final admission to Tri-Rivers/Marion General Hospital School of Paramedicine.

Applicant's Signature

Date



Tri-Rivers Public Safety Services Training Program
ODPS Accreditation #329

REFERENCE FORM

Applicant

Date

Street Address/Number

City, State, Zip

ATTENTION APPLICANT:

For which course are you applying?
(Place an 'X' in the appropriate space)

EMT-INTERMEDIATE _____

EMT-PARAMEDIC _____

Print the name & title of the person from whom you are requesting this reference:

Name

Title

You are required to choose three references who can provide this school with accurate information regarding your background and experience. We prefer you seek these references from Emergency Medical Service employers or their representatives who have observed you in your performance of duties and who can evaluate your ability to complete this educational process and competently perform the functions of EMS provider. An alternative may be an employer in a non-EMS field. No members of your immediate family please.

Please sign the form below, giving permission for the reference to release information about you, which will become a part of your permanent file. Ask the references to return the completed form promptly in a sealed envelope to the school's address, shown on the bottom of the page. It is the applicant's responsibility to see that all reference forms are received by the school in order for the application to be considered.

APPLICANT – PLEASE READ AND SIGN THE FOLLOWING STATEMENT:

I have applied at Tri-Rivers/Marion General Hospital School of Paramedicine for the course indicated above. I authorize the person named as reference to provide the information requested and return it to the Program Coordinator of the school. Information provided may be used in evaluating my ability to successfully complete the educational process and to competently perform the functions of **EMT-I or EMT-P.**
(circle one)

Signature of applicant

Date

Tri-Rivers Public Safety Services Training Program

REFERENCE FORM

NOTE TO PERSON PROVIDING REFERENCE

Thank you for agreeing to provide this reference for the applicant whose name appears on the reverse side of this form. This process is intended to be helpful to both the applicant and to the school in that the selection process will be expedited and strengths and weaknesses of the applicant can be determined fairly. Please note that the applicant has signed a statement authorizing you to provide the requested information. If you have any questions, what-so-ever, please do not hesitate to contact the Program Coordinator at the address below. Thank you for your assistance in this important educational endeavor.

Sincerely,

Regina Shumaker
Program Coordinator

Table with 6 rows and 5 columns. Columns are labeled: Very Strong-5, Strong-4, Not Sure-3, Weak-2, Very Weak-1. Rows contain evaluation questions for an EMT candidate.

Approximately how long have you known this candidate and in what capacity?

Please comment on any of the above questions or your responses. We also welcome your comments on anything we have not addressed in this questionnaire:

Signature

Title

Date

Company/organization

Please mail completed from to: Tri-Rivers Public Safety Services
2222 Marion-Mt. Gilead Road
Marion, OH 43302

Address

Phone: (740) 389-4681 Ext. 116
Fax: (740) 386-2403
email: ryake@tririverscc.org

City, state, zip

Phone:



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	Very Strong-5	Strong-4	Not Sure-3	Weak-2	Very Weak-1
1. Evaluate observed strengths of the candidate's skills as an EMT:					
2. Indicate your degree of confidence in the candidate's ability to succeed in this course:					
3. Rate candidate's rapport with co-workers:					
4. Rate candidate's rapport with supervisors.					
5. Rate candidate's rapport with patients/clients.					
6. How would you rate this candidate overall?					

Approximately how long have you known this candidate and in what capacity? _____

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email: ryake@tririverscc.org

City, state, zip

Phone: _____



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