

**MIAMI DADE COLLEGE  
MEDICAL CENTER CAMPUS  
SCHOOL OF HEALTH SCIENCES  
EMERGENCY MEDICAL SERVICES  
Paramedic Program Application Packet**

\_\_\_\_\_  
Student Name (Print)

\_\_\_\_\_  
Student Number

The information in this 8 - page packet **must** be completed to be considered an applicant for the Paramedic program at Miami Dade College. It is the applicant's responsibility to **provide all necessary documentation** for each of the required content areas. Please be sure to follow the instructions provided to ensure the submission of a complete application packet. **STUDENTS MUST MAKE AN EXTRA COPY OF THE STUDENT HEALTH RECORD AND ALL LAB TEST RESULTS AND SUBMIT IT WITH THE COMPLETED APPLICATION PACKET.**

**INSTRUCTIONS:**

**1. Paramedic Program Application: (Page 2)**

- a. Print your name and student number in the space provided
- b. Under **class preference** section, indicate which paramedic program you are applying to by placing an "X" in the box next the program.
- c. Under the **REQUIRED ITEMS/INFORMATION** section, provide the following information/documentation:
  1. Provide a copy of your current State of Florida EMT certification. (Individuals are eligible to submit the paramedic application packet without having a current EMT certification. However, this certification must be in place by the first day of the paramedic class).
  2. Provide a copy of your current CPR Certification (BLS for Health Care Providers or equivalent)
  3. Student Health Record – see instructions under Student Health Record
  4. Provide a copy of your current personal medical insurance card. Students are permitted to sign a waiver of financial responsibility in lieu of the medical insurance card.
  5. Provide a copy of the School of Justice email verification of successful completion of the required criminal background check. – see instructions under criminal background check
  6. Provide documentation of the completion, enrollment in, or transfer credit for Anatomy and Physiology 1 lecture and laboratory class (BSC 2085 and BSC 2085L). This can be provided by printing a MDC degree audit or unofficial transcripts. Students providing transfer credit documentation must also provide official transcripts to MDC.
  7. Provide documentation of acceptable scores or equivalent for CPT scores. Required scores to be eligible for acceptance are: Reading and English = 83 or higher, Algebra = 72 or higher.

**2. Student Health Record: (Pages 3 – 6) AN EXTRA COPY OF THE STUDENT HEALTH RECORD AND LAB RESULTS MUST BE SUBMITTED WITH THE PACKET AT THE TIME OF SUBMISSION.**

- All students participating in a medically related program offered through the Medical Center Campus must complete the **Student Health Record**. To be considered a complete Student Health Record, the application must provide the following:
- a. Documentation of immunizations from a physician and/or clinic patient record or actual lab results of the required titers
  - b. Actual laboratory results of the 5-panel drug screen test
  - c. Physician and/or clinic patient records of TB skin Test (chest x-ray results are only accepted in lieu of the TB skin test if there is a history of a positive skin test).
  - d. Documentation of Hepatitis B Vaccine or signed declination of the Hepatitis B Vaccine
  - e. Signature of the individual performing the examination of the application confirming the test results and the applicant's ability to meet the Physical Demands of the program. (Physician or clinic business card must be attached to the first page of the Student Health Record.

**3. Criminal Background Check: (Pages 7 – 8)**

All students participating in a medically related program offered through the Medical Center Campus must complete the **Criminal Background Check** process. **Students must follow the process identified on page 7 of this application packet and complete the required form on page 8. The applicant is responsible to provide a copy of the email verification of successful completion of the criminal background from designated Criminal Background Check provider to satisfy this requirement. The email notification is sent to the student's college email account.**

COMPLETED APPLICATION PACKETS ARE TO BE SUBMITTED TO THE EMS DEPARTMENT  
LOCATED ON THE MEDICAL CENTER CAMPUS, BUILDING TWO, 2<sup>ND</sup> FLOOR.

**MIAMI DADE COLLEGE  
 MEDICAL CENTER CAMPUS  
 SCHOOL OF HEALTH SCIENCES  
 EMERGENCY MEDICAL SERVICES  
 Paramedic Program Application**

Student Name (Print) \_\_\_\_\_

Student Number \_\_\_\_\_

Email address: \_\_\_\_\_

**Class Preference:**

	Fall Semester: B Shift, Medical Center Campus: 8:00AM – 9:00 PM
	Spring Semester: C Shift, Medical Center Campus: 8:00 AM – 9:00 PM
	Summer Semester: A Shift, Medical Center Campus: 8:00AM – 9:00 PM
	Evening Class, Medical Center Campus: Lecture 2 nights/week: 5:00PM – 9:00PM Clinic 2 nights/week: 5:00PM – 9:00PM Saturday Laboratory: 8:00AM – 4:00PM

**APPLICATION REQUIREMENTS:**

*THE FOLLOWING ITEMS MUST BE INCLUDED WITH THE APPLICATION TO BE ACCEPTED AND/OR REGISTERED FOR THE CLASSES ASSOCIATED WITH THE EMT PROGRAM. IT IS THE STUDENT'S RESPONSIBILITY TO PROVIDE ALL COPIES OF REQUIRED INFORMATION, HEALTH DOCUMENTATION, AND CRIMINAL BACKGROUND VERIFICATION.*

**REQUIRED ITEMS/INFORMATION**

	<b>COPY OF FLORIDA EMT CERTIFICATION</b>
	<b>COPY OF CURRENT CPR CERTIFICATION, BLS FOR HEALTH CARE PROVIDERS</b>
	<b>COMPLETED STUDENT HEALTH RECORD FORM (must include:) (with extra copy of form and test results)</b>
	Documentation of titer results for Varicella, Mumps, Rubella, and Rubeola
	Documentation of a 5 panel drug screen test
	Documentation of TWO (2) TB skin tests [performed within the last three (3) months]
	Signature of the health care examiner
	<b>COPY OF PERSONAL MEDICAL INSURANCE CARD</b>
	<b>COPY OF EMAIL DEMONSTRATING COMPLETION OF THE CRIMINAL BACKGROUND CHECK FROM THE DESIGNATED BACKGROUND CHECK PROVIDER. <i>Student must submit a copy of the email verification of successful completion of the criminal background to satisfy this requirement.</i></b>
	<b>DOCUMENTATION OF BSC 2085 AND BSC 2085L:</b>  _____ Completed      _____ Currently Enrolled      _____ Transfer Credit
	<b>PROOF OF ACCEPTABLE CPT SCORES OF EQUIVALENT</b>

**(STAFF USE ONLY)** Date Received: \_\_\_\_\_ Initials: \_\_\_\_\_

**Name:** \_\_\_\_\_ **Student Number:** \_\_\_\_\_  
Last First Middle Initial

I understand that student health information is protected and confidential under State of Florida and federal laws. I voluntarily provide, and consent to my medical provider or physician providing, the medical information contained in this document to the Miami Dade College and health care facilities that I am assigned to as part of Miami Dade College's medical program requirements. I also understand that all requested Student Health Record information is a prerequisite to enrollment in the clinical training of any Medical Center Campus program. Failure to complete this record will prevent my participation in the clinical training. The student and Health Care Examiner (MD, DO, PA, ARNP) must sign in the appropriate spaces provided on the form. **Documentation of all titers, drug screening, skin testing, and x-rays must be attached to the student health record.**

**SECTION 1: PERSONAL INFORMATION**

All areas of this section must be completed. This information will be kept on file and used in the event that the student must be contacted or an emergency contact is required.

**SECTION 2: REQUIRED TITERS/TESTS**

**A. Varicella (Chicken Pox):** A Varicella Titer must be drawn and *the results attached*. **A record of the Varicella Vaccine will not be accepted as documentation of the required titer.** The date of the titer and results must be indicated in the appropriate area. **(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).**

**Mumps, Rubeola (Measles), and Rubella (German Measles):** A Mumps, Rubeola, and Rubella Titer must be drawn and *the results attached*. **A record of the MMR (Mumps, Measles, Rubella) Vaccine will not be accepted as documentation of the required titer.** The dates of the titers and the results must be indicated in the appropriate area. **(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).**

**C. Drug Screening:** A 5-panel drug screen is required. **A positive result on this test will result in the student's inability to participate in the clinical portion of any Medical Center Campus program at Miami Dade College.** The results must be indicated and attached.

**D. TB Skin Test:** Two consecutive TB Skin Tests are required. The TB Skin tests can be repeated a minimum of three days apart. **The dates and results of each TB Skin Test must be attached.** The Skin Tests must have been performed within the last three (3) months to be considered a recent test. In the event the results indicate a positive skin test or the student has a history of a positive TB skin test, a chest x-ray is required.

**Chest X-ray:** A recent Chest x-ray is required if a positive TB skin Test is reported or there is a history of a positive TB Skin Test. The chest x-ray must have been completed within the last three (3) months to be considered current. **Results must be attached.**

**Section 3: Hepatitis B Vaccine**

Although this is not required, it is highly recommend that students participate in the Hepatitis B vaccine series. Further information of the Hepatitis B Vaccine is provided on the **Student Health Record Form** on pages 3. If declined, the student must sign the declination statement. **A record of the Hepatitis B Vaccine or antibody test results must be attached if not declined.**

**Section 4: Student's Statement**

Student must read and sign this statement on page 3 of the Student Health Record

**Section 5: Examiner's Statement**

The Health Care Examiner (MD, DO, PA, and ARNP) must read and sign this statement on page 3 of the Student Health Record.

<p><b>Please Place Health Care Provider Office Stamp or Attach Business Card Here (Required):</b></p>
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**SECTION 1: PERSONAL INFORMATION**

\_\_\_\_\_ Apt.# \_\_\_\_\_  
 Address \_\_\_\_\_ E-mail address \_\_\_\_\_  
 \_\_\_\_\_ Gender: M \_\_\_\_ F \_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Telephone Number \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Cellular Phone Number \_\_\_\_\_  
 \_\_\_\_\_ Relationship \_\_\_\_\_  
 Person to Notify in Emergency \_\_\_\_\_ Contact Telephone Number \_\_\_\_\_

**SECTION 2: REQUIRED TITERS/TESTS**

**Parts A, B, C: THESE BOXES ARE TO BE COMPLETED BY AUTHORIZED MEDICAL PERSONNEL ONLY**

**A. REQUIRED TITERS: (Documentation must be attached)**

A Varicella, Mumps, Rubeola (Measles), and Rubella (German Measles) Titer must be drawn and the results attached. **A record of Vaccines will not be accepted as documentation for the required titers.** The dates of the titers and the results must be indicated in the appropriate area below. ***(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).***

TITER	DATE	LAB RESULTS(Documentation must be attached) (Numerical Value of Results Must Be Reported Below)
Varicella Titer	____/____/____ Month Day Year	
Mumps Titer	____/____/____ Month Day Year	
Rubeola (Measles) Titer	____/____/____ Month Day Year	
Rubella (German Measles) Titer	____/____/____ Month Day Year	

**B. TB SKIN TEST/CHEST X-RAY**

Two consecutive TB Skin Tests are required. The TB Skin tests can be repeated a ***minimum of three days apart***. The dates and results of each TB Skin Test must be attached. The Skin Tests must have been performed ***within the last three (3) months*** to be considered a recent test. **In the event the results indicate a positive skin test or the student has a history of a positive TB skin test, a chest x-ray is required. The chest x-ray must have been completed within the last three (3) months to be considered current. Results must be attached.**

TEST	DATE	RESULTS	
TB Skin Test 1 <sup>st</sup> Test	____/____/____ Month Day Year	Positive _____ Negative _____	If positive skin test, current chest x-ray is required. <b><u>Results of TB skin test must be attached.</u></b>
TB Skin Test 2 <sup>nd</sup> Test	____/____/____ Month Day Year	Positive _____ Negative _____	If positive skin test, current chest x-ray is required. <b><u>Results of TB skin test must be attached.</u></b>
Chest X-ray	____/____/____ Month Day Year	Positive _____ Negative _____	<b><u>RESULTS OF CHEST X-RAY MUST BE ATTACHED</u></b>

### C. DRUG SCREENING

A 5-panel drug screen is required. A positive result on this test will result in the student's inability to participate in the clinical portion of any Medical Center Campus program at Miami Dade College. The results must be indicated and attached.

TEST	DATE	RESULTS	
Drug Screen (5 Panel – THC, COC, OPI, AMP, mAMP)	____/____/____ Month Day Year	Positive _____ Negative _____	<i>A positive result on this test will result in the student's inability to participate in the clinical portion of any Medical Center Campus program at Miami Dade College. RESULTS OF DRUG SCREEN TEST MUST BE ATTACHED.</i>

### SECTION 3: HEPATITIS

**Introduction:** Health care professionals are at risk of exposure to blood and body fluids contaminated with the viruses that cause HIV and Hepatitis. Consistent use of Standard Precautions is the best known means to avoid transmission of these viruses or other contaminants. Students will be taught Standard Precautions before they provide care to any patient in the clinical setting. Although it is rare, a health care worker may become exposed to one of these viruses through accidental transmission. Currently, there is no vaccine that protects against the HIV virus. However, the Hepatitis B vaccine is an effective means of preventing Hepatitis B. As a student who will be providing direct patient care, you should discuss this vaccine with your health care provider.

**About the Vaccine:** The Hepatitis B Vaccine is a genetically engineered "yeast" derived vaccine. It is administered in the deltoid muscle (arm) in a series of three doses over a six month period. You should seek additional information about the vaccine from your health care provider; especially if you have an allergy to yeast or may be pregnant, or are a nursing mother.

I have already completed, or am presently participating in, a Hepatitis B Vaccine Program

1<sup>st</sup> Dose: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

2<sup>nd</sup> Dose: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(One month after 1<sup>st</sup> dose)

3<sup>rd</sup> Dose: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Six months after 1<sup>st</sup> dose)

**OR**

Antibody testing has revealed that I have immunity to Hepatitis B. Yes \_\_\_\_\_ No \_\_\_\_\_

**(ATTACH COPY OF LAB REPORT).**

**OR**

I understand that, due to my occupational exposure to blood or other potentially infectious materials, I am at risk of acquiring Hepatitis B infection. I understand that the Hepatitis B Vaccine is recommended to help prevent illness due to the Hepatitis B Virus. I have discussed the risks and benefits with my personal health care provider and **decline** the Hepatitis B Vaccine at this time.

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### SECTION 4: STUDENT'S STATEMENT

In order to satisfy medical program requirements, I hereby consent to the release and disclosure of my personal health information provided on the **Student Health Record Form** to Miami Dade College and any health care facility in which I am assigned for on-site clinical training. I understand that my personal health information is required to facilitate my participation in the clinical training, which is required for program completion. I also hereby release and hold harmless Miami Dade College and receiving health care facilities from any claim of violation of HIPAA or any other medical privacy rights that may arise for the release of my personal health information provided in the **Student Health Record Form**.

Print Name: \_\_\_\_\_

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PHYSICAL DEMANDS**

In order to fulfill the requirements of the Emergency Medical Services Program at Miami Dade College, students must be able to meet the physical demands associated with the profession. Examples of these requirements include but are not limited to the following:

**Code: F = frequently    O = Occasionally    NA = Not Applicable**

Physical Demands	Code	Comments
Standing	F	Very little time is spent sitting down except for writing reports. Aptitude required for work of this nature are good physical stamina, endurance, and body conditions that would not be adversely affected by lifting, carrying and balancing at times. Motor coordination is necessary for the well being of the patient, the EMT/Paramedic and the co-worker over uneven terrain.
Walking	F	
Sitting	O	
Lifting (up to 125 pounds)	F	
Carrying	F	
Pushing	F	
Pulling	F	
Balancing	F	Climbing and balancing are required for safe transport of the patient and equipment. Patients are often found injured or sick in locations where removal is possible only through the EMT/Paramedic's stooping, kneeling, crouching and crawling.
Climbing	F	
Crouching	F	
Crawling	F	Transporting life saving equipment, arm extension, handling carefully patients in fragile conditions, feeling to assess vital signs are part of the nature of this position.
Stooping	F	
Kneeling	F	
Reaching	F	
Manual Dexterity	F	
Feeling	F	
Talking	F	
Hearing	F	
Seeing	F	
Communicating	F	

(For specific Performance Standards associated with the EMS Program please contact the Program Coordinator at 305-237-4337.

Limitations: \_\_\_\_\_  
 \_\_\_\_\_

**SECTION 5: EXAMINER'S STATEMENT**

I have verified that the individual I have examined is the named individual on this document and that the information about the immunizations, vaccines, and test results are correct. This individual can participate in all activities required to provide health care to patients in an acute or chronic care facility, emergency setting or any other situation that is part of the learning experiences in the designated health care program. PLEASE READ THE PHYSICAL DEMANDS that are listed above and list any limitations associated with this student in the area provided.

\_\_\_\_\_

MD/DO/PA/ARNP Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Office Telephone Number

\_\_\_\_\_

License Number

**MIAMI DADE COLLEGE  
MEDICAL CENTER CAMPUS**

**CRIMINAL HISTORY INFORMATION CHECKS REQUIRED FOR  
MEDICAL CENTER CAMPUS PROGRAM STUDENTS**

Florida law requires level 2 criminal background screenings for “all employees in position of trust or responsibility”, pursuant to §435.04, Florida Statutes (2004). The Joint Commission of Accreditation of Healthcare Organizations (JCAHO), a healthcare accreditation entity, also requires healthcare facilities to conduct background screenings on employees, students, and volunteers in accordance with state law and regulation and/or the internal procedures of the healthcare facility. The purpose of the level 2 criminal background screenings, which include fingerprinting and a state and federal criminal records check, is to ensure patient safety and maintain trust and integrity within the healthcare professions.

Many of the College’s healthcare training facilities now require the College to conduct level 2 criminal background screenings on all faculty, students and any other person who participates in clinical training at a healthcare facility. In response to this requirement, all faculty, students or any other persons that participate in the College’s clinical training programs are required to obtain a level 2 criminal background screening before beginning their participation or continuing their participation in any of the College’s clinical placement programs. In most instances, previous screenings are not accepted by the College.

To obtain the level 2 background check for your enrollment in your selected program at Miami Dade College, students should do the following:

- 1) Schedule an appointment at <http://ibrinc.com/mdc/select>
- 2) Follow the link identified as “Medical Campus Student”.
- 3) Complete the requested information for the completion of the background check process.

**MIAMI DADE COLLEGE  
MEDICAL CENTER CAMPUS**

**ACKNOWLEDGMENT AND CONSENT FOR RELEASE OF INFORMATION**

I understand that placement in a clinical setting is an essential component of my education in a health science program offered by the Medical Center Campus of Miami Dade College.

I have been informed that many healthcare agencies require a level 2 criminal background screening as a prerequisite for placement in an agency. I hereby consent to Miami Dade College receiving the results of my level 2 criminal background screening. I also understand that this information will be held confidential by the College and will not become a part of my student record. I give the College permission to disclose and/or share the results of the screening with a clinical agency for the sole purpose of clinical placement eligibility within a clinical agency.

I acknowledge that the clinical agency may make the determination, regarding specific criminal charges, that would disqualify me from participating in a clinical program, and that Miami Dade College is not involved in, and has no control over, that determination. I understand that if I am disqualified from participating in the clinical program as a result of the criminal background screening, I may not be permitted to continue in the Medical Center Campus program in which I am enrolled.

I hereby sign this form voluntarily with the understanding that a level 2 criminal background check is a prerequisite to clinical placement in a Miami Dade College Medical Center Campus program.

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Student Number: \_\_\_\_\_

Medical Center Campus Program \_\_\_\_\_

I have worked, resided or been a student in a state other than Florida, or a country other than the United States, during the past 24 months:

Yes \_\_\_\_\_ No \_\_\_\_\_.

If yes, name of state or country:

\_\_\_\_\_  
Student Signature