

Hendricks Regional Health Emergency Paramedic Program

COURSE APPLICATION

(Please print in INK)

PERSONAL DATA			
Name:	Last	First	Middle
			Phone
			()
Street Address		City	State
			Zip Code
E-Mail Address:			

Optional:	Social Security Number _____	Date of Birth _____	
	Age _____	Sex: M F	Marital Status _____
Indiana Basic EMT Certification Number _____ Expiration Date _____			
EMT Training Institution _____		Instructor _____	
National registry Cert. Number (If applicable) _____		Expiration _____	
CPR Certification Expiration Date _____			
List Other Medical Certification/ Licenses _____			

Name of Sponsoring EMS Provider: (If Applicable)	Name
	Address

Initial Basic EMT Certification Date _____

Have you previously been enrolled in a Paramedic Training Program: Yes No If YES, explain (attach Additional sheet of paper)

HEALTH

State of Health: Excellent Good Fair Poor

List Specific Problems: _____

Continued on back side

Hendricks Regional Health Emergency Paramedic Program

SCHOLASTIC BACKGROUND

High School Attended _____	
UNIVERSITIES OR COLLEGES ATTENDED	DEGREE(S) RECEIVED OR EXPECTED AND DATES
Grade point average _____ on a scale of _____ as of (date) _____	
List courses to be completed before graduation (if applicable) _____	

WORK EXPERIENCE

(List work experiences you have had. Use another sheet, if necessary.)

Organization 1	Dates Held
Address	
Position Held	Supervisor
Responsibilities	
Organization 2	Dates Held
Address	
Position Held	Supervisor
Responsibilities	

Continued on back side

Hendricks Regional Health Emergency Paramedic Program

WORK EXPERIENCE (cont.)

(List work experiences you have had. Use another sheet, if necessary.)

Organization 3	Dates Held
Address	
Position Held	Supervisor
Responsibilities	

Organization 4	Dates Held
Address	
Position Held	Supervisor
Responsibilities	

REFERENCES

List the Names, Titles, and Addresses of the three persons you have asked to submit a recommendation form in your behalf.
Select references who are in a position to comment competently on your probability of success in the program.

Name		Title	
Street Address	City	State	Zip
Name		Title	
Street Address	City	State	Zip
Name		Title	
Street Address	City	State	Zip

Continued on back side

Hendricks Regional Health Emergency Paramedic Program

SUMMARY

Please give a short summary of your reasons for wanting to be enrolled in the Emergency Paramedic Program.
(attach additional sheet(s) paper)

Have you ever been convicted of a felony under state or federal law?

YES

NO

Conviction	County/State	Dates
Conviction	County/State	Dates
Conviction	County/State	Dates

NOTE: Conviction means you were found guilty by a judge, jury, "no contest", or guilty plea in court
A conviction may be taken place even if you did not pay a fine or spend any time in a jail or prison.
A conviction will NOT automatically disqualify you from enrollment. Hendricks Regional Health policy will determine which convictions disqualify you from enrollment. Any misrepresentation **WILL** disqualify you from enrollment

Do you have an addiction to or dependence upon alcohol, barbiturates, amphetamines, hallucinogens, or other drugs?

YES

NO

I do hereby certify that:

1. I am the applicant named and that I am requesting admission to the Hendricks Regional Health Paramedic Education Program
2. I have read and understand the program prerequisites and do hereby meet those prerequisites unless exceptions have been identified above.
3. I do not have any medical condition (other than listed on my physical examination form) that requires continuous treatment. In addition, I am not aware of any medical condition (physical or mental) that would affect my performance as a student or a paramedic.
4. I understand that my application will not be complete until letters of recommendation have been received, and I have completed any and all necessary entrance examinations.
5. I understand that entrance into the program does not guarantee successful completion of the program.
6. I understand that completion of this education program will not authorize or grant me any right to perform those advance life support activities in which I will be trained.
7. I have read all of the above statements and do declare these statements to be true to the best of my knowledge
8. I understand that if I am accepted into the Paramedic Program, Hendricks Regional Health will not be held responsible for any injury to myself or damage to my property which I may incur in connection with my participation in the program, unless such injury or damage is caused by the negligence of Hendricks Regional Health, its employees, or its agents.

Continued on back side

Hendricks Regional Health Emergency Paramedic Program

9. I understand that all statements made in this application are accurate and complete, and are subject to verification. Should falsification of this document be demonstrated, I may be denied admission; or, if I have begun training, I will be subject to immediate expulsion without refund of tuition and/ or fees paid.

Signature of Applicant	Date
------------------------	------

REFERENCE FOR APPLICANT TO PARAMEDIC TRAINING PROGRAM

Applicant's Name:	First	Middle	Last
-------------------	-------	--------	------

You Must provide one reference from each of the following categories

1. Someone familiar with your Basic EMT skills / experience
2. Personal reference (not related)
3. Present or last employer

Name of Reference who is recommending you to participate in the Paramedic Program

Name			
Address			
City	State	Zip	County
Telephone (Business)		Telephone (Home)	
Reference's Title / Position			
Signature		Date	

To the Respondent:

We are particularly interested in your assessment of the applicant's ability to follow orders reliably; maturity of judgement; the applicant's attitude; motivation and dependability; and his/ her potential as a future paramedic. Also identification of any area in which the applicant needs to concentrate for continuing development will be of assistance. A brief letter of explanation regarding your response is requested. You may use the back of this form, if you wish. When this form has been completed, it is to be mailed directly to:

Paramedic Program Director
 Hendricks Regional Health
 1000 E Main Street
 Danville, IN 46122

Please check:

- Highly recommend Recommend Recommend with Reservation Not Recommend

If you have any questions, please call 317-745-3559

PHYSICIAN RECOMMENDATION FORM

Applicant's Name:	First	Middle	Last
-------------------	-------	--------	------

Name of Physician who is recommending you to participate in the Paramedic Program

Physician's Name			
Address			
City	State	Zip	County
Telephone (Business)		Telephone (Home)	

I hereby recommend the above named individual for participation in the Hendricks Regional Paramedic Program

I believe this person to be a successful candidate

Physician's Name Printed	
Physician Signature	Date

To the Respondent:

We are particularly interested in your assessment of the applicant's ability to follow orders reliably; maturity of judgement; the applicant's attitude; motivation and dependability; and his/ her potential as a future paramedic. Also identification of any area in which the applicant needs to concentrate for continuing development will be of assistance. A brief letter of explanation regarding your response is requested. You may use the back of this form, if you wish. When this form has been completed, it is to be mailed directly to:

Paramedic Program Director
Hendricks Regional Health
1000 E Main Street
Danville, IN 46122

Please check:

Highly recommend Recommend Recommend with Reservation Not Recommend

If you have any questions, please call 317-745-3559