Yale NewHaven Health
Yale New Haven Hospital

CPR Training Professionals, LLC
EMS Division
www.ctemsclasses.com

CPR Training Professionals EMS Paramedic Program Application

Program being applied for: **2023 Certificate Paramedic**

Program Start Date: **Program January 14, 2023**

Application Deadline*: **December 15, 2022**

***Class size will be limited to a maximum of 24 students. In the event that there are seats available in the class after the application process, late applications will be accepted up until 1 week before the start of class on a first come, first serve basis.**

Please fill out application completely in blue or black ink. If a section or line does not apply to you, please mark as N/A.

Demographics

Name: _____ DOB: _____
First Middle Last

Home Address: _____ City/Town: _____ State: _____ Zip: _____

SSN: _____ E-Mail Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Driver's License Number: _____ Expiration Date: _____ State: _____

EMT Certification Number: _____ Expiration Date: _____ State: _____

How did you hear about us? _____

Primary EMS Employer/Service

Organization Name: _____ Phone Number: _____

Address: _____ City/Town: _____ State: _____ Zip: _____

Position: _____ Date Employed: _____ To: _____

Duties/Responsibilities: _____

Supervisor: _____ Title/Rank: _____

Supervisor's Signature: _____ Date: _____

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Secondary EMS Employer/Service (if applicable)

Organization Name: _____ Phone Number: _____

Address: _____ City/Town: _____ State: _____ Zip: _____

Position: _____ Date Employed: _____ To: _____

Duties/Responsibilities: _____

Supervisor: _____ Title/Rank: _____

Supervisor's Signature: _____ Date: _____

Past EMS Employment or Volunteer Membership

Please include ALL PRIOR EMS affiliations beginning with the most recent.
Attach separate sheet if necessary.

Organization Name: _____ Phone Number: _____

Address: _____ City/Town: _____ State: _____ Zip: _____

Position: _____ Date Employed: _____ To: _____

Duties/Responsibilities: _____

Supervisor: _____ Title/Rank: _____

Organization Name: _____ Phone Number: _____

Address: _____ City/Town: _____ State: _____ Zip: _____

Position: _____ Date Employed: _____ To: _____

Duties/Responsibilities: _____

Supervisor: _____ Title/Rank: _____

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Non-EMS Employment

Organization Name: _____ Phone Number: _____

Address: _____ City/Town: _____ State: _____ Zip: _____

Position: _____ Date Employed: _____ To: _____

Duties/Responsibilities: _____

Supervisor: _____ Title/Rank: _____

Organization Name: _____ Phone Number: _____

Address: _____ City/Town: _____ State: _____ Zip: _____

Position: _____ Date Employed: _____ To: _____

Duties/Responsibilities: _____

Supervisor: _____ Title/Rank: _____

Organization Name: _____ Phone Number: _____

Address: _____ City/Town: _____ State: _____ Zip: _____

Position: _____ Date Employed: _____ To: _____

Duties/Responsibilities: _____

Supervisor: _____ Title/Rank: _____

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Military Service

Branch: _____ Current Status: _____

Rank: _____ Dates of Service: _____ To: _____

Duties/Responsibilities: _____

Type of Discharge: _____

Education

School: _____

Address: _____ City/Town: _____ State: _____ Zip: _____

Dates Attended: _____ Years Completed: _____ Degree: _____

If no degree, courses attended: _____

School: _____

Address: _____ City/Town: _____ State: _____ Zip: _____

Dates Attended: _____ Years Completed: _____ Degree: _____

If no degree, courses attended: _____

School: _____

Address: _____ City/Town: _____ State: _____ Zip: _____

Dates Attended: _____ Years Completed: _____ Degree: _____

If no degree, courses attended: _____

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Have you ever had any felony or criminal convictions other than minor traffic violations?

Yes_____ No_____

If **YES**, please explain. _____

Applicant Signature _____ Date _____

Notary Public _____ Date _____

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RELEASE OF INFORMATION

Authorization to release information to CPR Training Professionals.

TO: _____
Employer/ school

I, _____, authorize you to release to CPR Training Professionals and representatives of CPR Training Professionals, any information necessary to evaluate my credentials, appropriateness, or health relative to my application for Paramedic Training. This release is valid for a period of twenty-four (24) months from this date.

_____ _____
Applicant Signature Date

_____ _____
Notary Public Date

Note to Candidate:

Submit one for each employer or school listed above

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HEALTH INSURANCE WAIVER

I, _____, understand that in the course of my paramedic training, I may have an increased risk of exposure to hazardous situations and/or infectious diseases. I agree to maintain personal health insurance during my training and understand that the CPR Training Professionals/Yale New Haven Hospital Center for EMS paramedic program will not provide such coverage. Furthermore, the CPR Training Professionals /Yale New Haven Hospital Center for EMS paramedic program and its clinical affiliates and internship sites will not provide worker's compensation insurance to students for training related illnesses or injuries.

_____ _____

Applicant Signature Date

_____ _____

Notary Public Date

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SUBSTANCE ABUSE FORM

I certify that I am not actively addicted to alcohol or other drugs. I certify that I have no substance abuse or alcohol problems and that I do not use illegal drugs. I understand that discovery of such addiction or use may be reason for dismissal from the program.

Applicant Signature	Date
Notary Public	Date

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HEPATITIS B FORM

I have been advised by the CPR Training Professionals Paramedic program that I should be vaccinated against Hepatitis B, and if I decline, I understand I will likely be exposed to hepatitis B and other infectious diseases and that contracting the illness may have serious consequences, including that of death. I further understand that failure to have various up to date vaccinations and provide proof of the same, may preclude me from participating in clinical experiences and field internship necessary for successful graduation.

_____ _____

Applicant Signature Date

_____ _____

Notary Public Date

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Hepatitis B Vaccination Declination

(Only fill out if you choose NOT to get vaccinated for Hepatitis B virus)

Student Name: _____ Date of Birth: _____

I understand that due to my occupational exposure to blood or other potentially infectious materials during my clinical and field internship rotations, I may be at risk of acquiring the hepatitis B virus (HBV) infection. I decline receiving the hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials while at clinical and field rotations and I want to be vaccinated with hepatitis B vaccine, I may do so and rescind this declination.

Reason for Declination: _____

Signature: _____ Date: _____

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I attest that all information in this application is correct and truthful. I understand that discovery of falsification of the above is full and sufficient reason for dismissal from the program. I have read the program description and information.

_____	_____
Applicant Signature	Date
_____	_____
Notary Public	Date

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Application Check List

- [ ] Completed and notarized application packet
- [ ] Photocopies of the following items
  - Driver's License
  - EMT Certification
  - CPR Certification
  - Diploma (High School or College)
  - ICS 100, 200, 700, 800 Certifications
  - Proof of Positive Titer (from the current calendar year) of:
    - MMR
    - Varicella
    - Hepatitis B (or waiver)
  - Proof of TDAP vaccination
  - Proof of COVID vaccination with booster
  - PPD or equivalent (from the current calendar year)
- [ ] School transcripts (most recent degree/diploma received)
- [ ] Completed health assessment form
- [ ] Three (3) letters of recommendation
- [ ] Typed essay on "The Future of Paramedicine" (minimum of 2 pages)

All items must be present in order for application to be accepted. The only exception to this will be if a candidate's transcripts are being sent directly to CEMS from the issuing institution, however application will not be processed until transcripts have been received.

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Paramedic Program Health Assessment Form

Student information

Name	DOB	Male ☐ Female ☐
Street Address	City/State/Zip	
Phone (Day)	Phone (Evening)	
Phone (Cell)	Other#	
Email address		

Person to Notify in case of Emergency

Name	Relationship
Street Address	City/State/Zip
Phone (Day)	Phone (Evening)
Phone (Cell)	Other #
Email address	

Student Past Medical History

Current Medical Problems
Past Medical History
Past Surgical History
Allergies
Medications

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Paramedic Program Health Assessment Form

Immunizations: Titers Required for MMR, Hep B (or declination), Varicella and Proof of Vaccination for TDAP and COVID (with booster)

MMR	Varicella
TDAP	Influenza
Hep B	COVID

Physical Exam: Check if normal; describe if abnormal

	Check If Normal	Describe Abnormal
HEENT		
Neck		
Lungs		
Heart		
Abdomen		
Lymphatic		
Extremities		
Neurological		
Ortho		
PPD/Date		

SIGNATURES REQUIRED: At the time of this exam, this individual is physically capable of performing the physical duties required of an EMT/Paramedic and is free of any evidence of communicable disease.

Examiner's signature: MD, DO, PA, NP	**Date:**