AMERICAN / BACKUS

PARAMEDIC PROGRAM CONSORTIUM

2019-2020
Prospective Student Information and Application

American Professional Educational Services
One American Way
Norwich, CT 06360
Phone: 860-886-2737
americanprotraining.com

General Information

American Professional Educational Services was founded in 1996 in response to an increased demand for community CPR classes and soon expanded to include Emergency Medical Technician and Refresher Programs. In 2001, American Professional Educational Services conducted its first Paramedic Training Program. In addition to EMS programs, American Professional Educational Services offers other allied health programs and is licensed as an Occupational School by the Connecticut State Office of Higher Education. All programs exceed state and federal standards and pass rates for licensure, consistently exceeding the national average.

American Professional Educational Services is also proud to hold the distinction of being a Nationally Certified American Heart Association Training Center. We provide First Aid, CPR and AED (Automatic External Defibrillator) training to the general public as well as to health, recreation, hospitality and industrial clients. Our highly skilled AHA training staff also provides critical care health providers with training in Advanced Cardiac Life Support and Pediatric Advanced Life Support by using state-of-the-art manikin simulators.

The American Professional Educational Services Training Center is located in the lower level of the American Ambulance Service building in Norwich, CT. We have multiple training rooms, clinical labs, a computer lab and conference room. Our training rooms are equipped with an audio-visual system, LCD projector and DVD capabilities. Being co-located with American Ambulance Service, Inc. allows for better training and internship abilities as both establishments have vested interest in the Paramedic Program.

The American/Backus Paramedic Program Consortium is a joint venture between American Professional Educational Services and Hartford Healthcare's William W. Backus Hospital, dedicated to providing our students with the cognitive, psychomotor, affective and leadership skills necessary to provide the highest quality care to patients in the pre-hospital setting. The goal of the program is to prepare competent entry-level Paramedics.

Program tuition is $12,500.00 and includes all instruction, lab materials, uniform shirts, clinical with clinical instructor in attendance, and various certification programs through the American Heart Association and the National Association or Emergency Medical Technicians.

Applicants will not be discriminated against on the basis of sex, race, national origin, religion, age or sexual preference

The American/Backus Paramedic Program Consortium is accredited by the Commission on Accreditation of Allied Health Education Programs (www.caahep.org) upon the recommendation of the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP).

To contact CAAHEP:
1361 Park Street
Clearwater, FL 33756
(727) 210-2350
www.caahep.org

To contact CoAEMSP:
8301 Lakeview Parkway, Suite 111-312
Rowlett TX 75088
(214) 703-8445
FAX (214) 703-8992
www.coaemsp.org

Paramedic Education Program Prerequisites

- ☐ High School diploma or GED
- ☐ Be at least 18 y/o on the first day of class
- ☐ Be a certified/licensed EMT or AEMT
- ☐ Applicant must be a certified in Healthcare Provider CPR or comparable
- ☐ Applicant must be able to perform the functional job description of a Paramedic

Paramedic Program Application Checklist

- ☐ A complete and signed Paramedic Program Application
- ☐ Recommendation letters
  - A total of 3 letters of recommendation are required.
  - 2 of the letters must be professional references (employer, instructor, department chief, etc.)
- ☐ Copy of high school diploma or equivalent
- ☐ Copy of valid driver's license or state issued ID card
- ☐ Copy of a current EMT certification
- ☐ Copy of a current Healthcare Provider CPR certification
- ☐ Completed personal statement
  - A brief essay that describes why you are choosing the career field of Paramedicine. Provide insight to personal experience, skills and abilities relative to the role of an EMS provider. Your personal statement must be typed and between 450 and 500 words; double-spaced, in size 12 Times New Roman font with your name in the heading.

Things You Will Need Once Selected

- ☐ Interview with program administration
- ☐ Textbooks
- ☐ Completed physical form
- ☐ Liability insurance (prior to clinical rotations)
- ☐ Proof of Hepatitis-B vaccination or signed waiver provided by program (prior to clinical rotations)
- ☐ Proof of MMR immunization or titer (prior to clinical rotations)
- ☐ Proof of Varicella (chicken pox) immunization or titer (prior to clinical rotations)
- ☐ Proof of a negative TB test within the last year (prior to clinical rotations)

Paramedic Program Application

PERSONAL INFORMATION

Name____ **Birth Date**___________________

Home Address ____

City/Town ____________________ **State and Zip** ____________________

Social Security ____________________ **E-Mail Address** ____________________

Phone Number ____________________ **Cell Number** ____________________

Driver's License ____________________ **Expiration Date** ____________________

Level of Cert / # ____________________ **Expiration Date** ____________________

GENERAL INFORMATION - REQUIRED

Have you had any felony or criminal convictions other than traffic violations? ☐ Yes ☐ No If YES, attach a signed note of explanation in an envelope **sealed and marked** "Confidential".
Have you ever been employed under another name? ☐ Yes ☐ No If yes, provide the name(s) and specify the employer(s):
If you are presently employed, may we contact your employer for a reference? ☐ Yes ☐ No If no, please explain:
Have you ever been discharged from a job? ☐ Yes ☐ No If yes, please explain:
Can you furnish proof that you are either a US citizen or otherwise legally permitted to work in the US? ☐ Yes ☐ No If no, please explain:
Have you ever previously applied to this program? ☐ Yes ☐ No If yes, when?:

EDUCATION INFORMATION

Schools Attended	Dates Attended (month/year)	Status	Certs/Diplomas/Degrees
High School: ______________________ Street: ____________________________ City: __________________ State: _____ Phone: ___________________________	From: To:	Years/Units Completed: _____ Presently Enrolled: ☐ Y ☐ N Date Graduated: __________ Approximate GPA: _________	Diploma ☐ Yes ☐ No
EMT School: ______________________ Street: ____________________________ City: __________________ State: _____ Phone: ___________________________	From: To:	Date Completed: __________ Cert Number: _____________ Expiration Date: ___________	N/A
College: ___________________________ Street: ____________________________ City: __________________ State: _____ Phone: ___________________________	From: To:	Years/Units Completed: _____ Presently Enrolled: ☐ Y ☐ N Date Graduated: __________ Approximate GPA: _________	Major: __________________ Degree/Cert/Diploma ☐ Yes ☐ No

EMS Employment and Membership

Employer/Department	Dates (month/year)	Details
Company: _________________________________ Supervisor: _______________________________ Street: ___________________________________ City: _______________________ State: _________ Phone: ___________________________________	From: To:	Title: ____ Duties: ____ ____ Approx Hrs. / Week: ________________________________ Reason for Leaving: ________________________________
Company: _________________________________ Supervisor: _______________________________ Street: ___________________________________ City: _______________________ State: _________ Phone: ___________________________________	From: To:	Title: ____ Duties: ____ ____ Approx Hrs. / Week: ________________________________ Reason for Leaving: ________________________________

Company: ______	From:	Title: ______
Supervisor: ______		Duties: ______
Street: ______	To:	______
City: ______ State: ______		Approx Hrs. / Week: ______
Phone: ______		Reason for Leaving: ______

VETERAN'S INFORMATION

Are you a veteran of the US Armed Forces ☐ Yes (Complete the information below) ☐ No (Skip to signatures)

What branch of the US military have you served in: ______________________________

Dates of Service, From:______________________ To______________________

Current Status: ______________________________

Type of Discharge:______________________________

Will you apply for Veteran's Assistance benefits to attend the Paramedic Program? ☐ Yes ☐ No

- I hereby certify that all statements made on or in connection with this application are true to the best of my knowledge and belief. I understand and agree that any false statement or omission of material fact may disqualify me from consideration for acceptance to the American/Backus Paramedic Program Consortium Paramedic Program. Additionally, I authorize the program to verify the statements made on or in connection with this application.
- I also certify that I have received a copy of the application packet that contains rules, regulations, course completion requirements, and costs for the Paramedic Education program.
- It is the responsibility of the applicant to ensure all required documents have been submitted with this application. Failure to submit all required documentation including transcripts will result in the candidate not being considered for the program.

______________________________ ______________________

Applicant's Signature Date

FOR OFFICIAL USE ONLY

Application Received:______________________ Reviewed By: ______________________

Application Complete: □ Yes □ No

If no, what is missing: ______________________________

PHYSICAL EXAMINATION INSTRUCTIONS

Schedule a physical exam with your personal healthcare provider. Please be aware that some healthcare providers may not be able to schedule a physical exam on short notice. Don't wait to set up an appointment! The person conducting the exam and signing the form must be a licensed Physician, Physician Assistant, or APRN.

You must complete a Physical Exam and have the EMS Programs Physical Examination Form (see attached) completely filled out by the Physician conducting the exam.

Return the completed form to American Professional Educational Services. You will not be allowed to attend class until your physical exam form is received and approved by the EMS Programs Director.

The Physical Examination Form must be returned to the ALS Program Coordinator.

CONFIDENTIALITY

ALL STUDENT RECORDS WILL BE KEPT CONFIDENTIAL.

American Professional Educational Services will not release a student's records or health related information to anyone but that student or a contracted clinical site, unless written permission is provided directly from the student to release such information.

Clinical sites will maintain record confidentiality.

IMMUNIZATIONS

It is required that all paramedic students have the following vaccinations/tests and that they remain current throughout the duration of the program:

- **TB/ PPD Mantoux (Tuberculosis):** This test is required and must be current throughout your clinical rotation time. This test is valid for one year. Depending on the facility, this test may have to be repeated prior to starting or finishing clinical time.
- **Influenza:** This vaccination is required and must be current throughout your clinical rotation during flu season (October to May). It must be received at the beginning of the season or prior to the start of clinical rotation.
- **MMR (Measles, Mumps, Rubella):** All Paramedic students must provide proof of immunization for MMR. You are required to have received two (2) sets of injections. Most people receive these shots in early childhood, and then have them repeated later in their teens or pre-college years. If you are unable to obtain documentation, a physician can order a blood test requesting a MMR titer.
- **Chicken Pox (Varicella):** All Paramedic students must provide proof of immunization for Varicella. Most people receive these shots in early childhood, and they may be repeated later in their teens or pre-college years. If you are unable to obtain documentation, a physician can order a blood test requesting a Varicella titer. Physician documented proof of Varicella disease is acceptable as well.
- **TD (Tetanus):** All Paramedic students must provide proof that they have received a tetanus booster within the past 5 years.
- **Hepatitis B:** All Paramedic students are encouraged to receive the three (3) part injection series. A student may opt not to have this vaccination; however, a signed and witnessed affidavit of waiver must be completed and kept on file. Clinical sites may reject a student for not having this immunization series.

To satisfy program requirements for vaccinations, students are required to provide proof of vaccinations and immunity by virtue of titer, if applicable. If Paramedic students are deficient in any of the required vaccinations, they will be required to obtain said vaccinations and/or titers prior to attendance in clinical settings. These tests are the student's requirement and will not be provided by the program or clinical site. Clinical sites reserve the right to alter health requirements at any time.

STUDENT PERFORMANCE STANDARDS

Students must possess sufficient physical, motor, intellectual, emotional and social/communication skills to provide for patient care and safety, and the utilization of equipment. Performance standards for Emergency Medical Services students (Emergency Medical Technician and Paramedic) are based on information from the United States Department of Transportation Job Task Analysis.

EMS STUDENT PERFORMANCE SKILLS

Critical Thinking
Critical thinking sufficient for emergency medical judgment: Independent judgments in a physician's absence; Determine treatment priorities; Make quick decisions.

Interpersonal
Interpersonal abilities sufficient to interact with individuals, families and groups from a variety of social, emotional, cultural, and intellectual backgrounds: Life and death situations; Family stress of patient's illness; Peer stress from critical incident; Cultural diversity in reactions to illness or injury.

Communication
Communication abilities sufficient for interaction with others in verbal and written form: Radio report of patient condition; Comprehensive written reports of patient condition and treatment; Verbal report to other health care providers.

Mobility
Physical abilities sufficient to climb, stoop, crouch, kneel, and lift 125 lbs., drag, crawl, balance, reach, push, carry, bend, walk, run, and shuffle: Work in natural and man-made disasters; Move patients from incident to safety.

Motor Skills
Gross and fine motor abilities, finger dexterity, vision and hand movements sufficient to provide safe and efficient emergency care: Tie a knot, bandage; Give injections; Pick up small objects; Write with a pen.

Hearing
Auditory ability sufficient to monitor and assess health needs: Auscultation of breath sounds; Converse with patient; Work around loud equipment, on roadway; Hear radio transmissions and pager tones; Talk on telephone.

Vision
Visual ability sufficient to work in dark or dimly lit, bright light, and have spatial aptitude and form perception and color discrimination: Reading and writing reports; Visualize mechanism of injury in relation to patient's condition; Describe size and shape of wound; Describe patient's skin color.

Tactile
Tactile ability sufficient for physical assessment: Perform palpation, See motor skills.

Environmental Adjustment
Ability to provide patient care in a variety of locations and conditions: Deliver patient care in all weather conditions, in water, mud, roadways, fields, buildings, high and low elevations, in hot or cold air temperatures.

PHYSICAL EXAMINATION FORM

The EMS student's physical examination provides evidence that the student can meet the demands of physically and emotionally challenging training without becoming a hazard to themselves, EMS personnel or their patients. A licensed physician, physician assistant, or APRN must complete this form.

Applicant/Patient Name (PRINTED): ____

Date of Birth: ______________________ Date of Examination: ______________________

MEDICAL HISTORY (CHECK ALL THAT APPLY)

Does the applicant/patient have a history of:

_____	Asthma	_____	Diabetes Mellitus	_____	Prior Surgery
_____	Chronic Cough	_____	Orthopedic Disorders	_____	Substance Abuse
_____	COPD	_____	Seizure Disorders	_____	Drug Allergies
_____	Syncope	_____	Cardiac Abnormalities	_____	Tuberculosis
_____	Frequent Headaches	_____	Hernia	_____	Emotional Disorders
_____	GI Disorders	_____	Thyroid Disorder	_____	Back or Neck Problems
_____	Chicken Pox (Varicella)	_____	Urticaria	_____	Neurological Abnormality
_____	Smoking	_____	Varicose Veins	_____	Other

Please provide information concerning any boxes checked: ______________________________

____

____

Present Medications: ____

Allergies: ____

Reactions: ____

PHYSICAL EXAMINATION

Height: ________________________ **Weight:** ________________________

Vision Acuity: ____________________ **Vision Corrected: 20/ (Left)**

Color Vision: _____________________ **Vision Corrected: 20/ (Right)**

HEENT: ________________________ **Hearing Assessment:** __________________

Cardiopulmonary: ___________________ **Neurological:** ______________________

Abdominal: ______________________ **Muschloskeletal:** ____________________

Back: __________________________ **GU:** ______________________________

General: ____

Functions that are essential for EMS students, as adopted from the U.S. Department of Transportation Functional Job Analysis, are listed below. Please verify the following items by initialing.

__________ **GENERAL PHYSICAL CONDITION**: Physical stamina; endurance and body condition that would be adversely affected by frequently having to walk and stand, lift, carry, and balance at times in excess of 150 lbs, in setting that may be outdoors in hot, wet, and slippery environments.

__________ **MOBILITY:** Normal gait and motor coordination is necessary because over uneven terrain, patients, students, and other worker's well being must not be jeopardized. Mobility also includes the ability to knell, crouch, crawl, and reach to perform proper patient care.

__________ **FINE MOTOR SKILLS:** Finger dexterity, vision, and hand movements sufficient to tie a knot, bandage, give injections, pick up small objects, and write with a pen.

__________ **NORMAL SENSES:** Ability to talk, hear, smell, and see including normal fields of vision, depth perception, and color vision are required to assess patients and to protect patients from hazard.

__________ **ENVIRONMENTAL ADJUSTMENT:** Ability to focus on the best care possible in often adverse and dangerous situations. There may be exposure to a variety of noise levels, which at times can be quite high, particularly, when multiple sirens are sounding, and crowds/bystanders/families may be upset, crying hysterically, and making demands that may or may not be reasonable.

I hereby certify that ______________________________has been examined by me on ____________________(date) and is found to be in good physical and mental health and is able to undertake the training of the Emergency Medical Services Program.

Practitioner Name (PRINTED): ____

Signature: ____

Licensed as: **Physician ______** **P.A. ______** **APRN ______**

Telephone: _________________________________

Please Place Health Care Provider Office Stamp or Attach Business Card Here (Required):

Student Immunization Record

Name: ____ Date of Birth__________________________

Immunization	Immunization or Lab Test Date	Please Attach Documentation
MMR (measles, mumps, rubella) **OR** Measles (rubeola) Mumps Rubella	1. ___________ 2. ___________	A. ____Record of immunization **OR** A. ____Positive antibody titer A. ____Positive antibody titer A. ____Positive antibody titer
Varicella (chicken pox)	1. ____________ 2. ____________	A. ____Record of immunization B. ____Positive antibody titer
Hepatitis B	1. _____________ 2. _____________ 3. _____________	A. ____Completed series B. ____In progress series C. ____Positive antibody titer
Tetanus-Diphtheria	1. _____________	A. ____ Record of immunization
Influenza (if possible)	1. _____________	A. ____ Record of immunization
Tuberculin Skin Tests	1. _____________	A. ____Record of negative ppd B. ____Negative Chest X-ray

Practitioner Name (PRINTED): ____

Signature: ____

Licensed as: **Physician ______** **P.A. ______** **APRN ______**

Please Place Health Care Provider Office Stamp or Attach Business Card Here (Required):