# Mobile Intensive Care Services of Mary Greeley Medical Center
# Winter 2016
# Emergency Medical Technician Course

December 1st, 2016 – March 4th, 2017

The EMT course emphasizes the development of student skills in patient assessment and examination, the recognition of signs and symptoms of illness and injury, and proper procedures when rendering emergency medical care.

Course content will address broad topics and create a foundation of knowledge and skills preparing students who successfully complete the program for certification testing as a National Registry EMT and State of Iowa EMT.

Classes will meet on Monday, Tuesday and Thursday evenings from 6 PM until 10 PM, at Mary Greeley Medical Center in Ames. Occasional Saturdays may be needed.
To successfully complete the course students will be required to gain clinical experiences with Mobile Intensive Care Services and in the Mary Greeley Medical Center Emergency Department.

(Individual student hours may vary depending on the availability of patient contact.)

Courses will be coordinated and instructed by professional paramedics affiliated with Mobile Intensive Care Services of Mary Greeley Medical Center and other experienced clinicians with specialized expertise.

Admission Criteria:

- Be at least 18 years of age by March 3rd, 2017.
- Be functionally able to speak, read and write in English.
- Hold a current course completion card in CPR

  (Can be obtained on November 30th if needed)

Course Fees:
Tuition including the required text and workbook: $1100.00

Students will be responsible for testing fees payable to the Iowa Department of Public Health, Bureau of Emergency Medical Services and National Registry of Emergency Medical Technicians after successful completion of the course.

Inquiries may be directed to…

EMT Program Coordinator
Mary Greeley Medical Center
Adam Dunlap, Paramedic
dunlap@mgmc.com
515-239-2109

**APPLICATION FOR 2016 EMERGENCY MEDICAL TECHNICIAN COURSE**

## Please Print Clearly

Applications must be received by November 1st, 2016. Notice of acceptance will be given on or before November 15th, 2016.

Full Name: _____E-Mail: _____

Mailing Address:_____

City and State:_____Zip: _____

Phone: _____SSN: _____Date of Birth: _____

EMS Service Affiliation if Applicable: _____

Describe your healthcare background and any relevant certifications or licenses...

Describe why you want to enroll in this program and what you hope to gain from it…

Are you currently certified in AHA BLS for the Healthcare Provider? _____
If not, a class is scheduled for Wednesday, November 30th from 6-10 pm.
If you are currently certified please attach a photocopy of your card to this application.

A background check will be performed by Mary Greeley Medical Center on all applicants.

**Submit this form and any additional relevant documentation to…**

**Mobile Intensive Care Services**
**Adam Dunlap, EMT Program Coordinator**
**Mary Greeley Medical Center**
**1111 Duff Avenue**
**Ames, Iowa 50010**

Below is a list of required document information to be submitted with your application.

- ☐ Copy of a current Healthcare provide BLS (Basic Life Support) Card
- ☐ Copy of a current Mandatory Reporter Child/Dependent Adult Abuse Certificate. Certificate must be a combination of Child and Adult Abuse, and must have an Approval # listed on the certificate.
- ☐ Completed Background check forms
- ☐ Immunization Records

**If you have not had a TB Skin Test or Physical within the last 12 months, or one of the required immunizations, you will need to see your primary physician to complete the requirement.** Your physician will then provide you with the physician/clinic documentation to submit. It will be helpful to contact past/current schools/universities, employers, and Physicians/Clinics for your records.

- ☐ **Copy of Health Screening (physical) within the past 12 months (required by law every 4 years) –** must include documentation of full set of vitals.
- ☐ **TB test - Physician/Clinic documentation within the past 12 months**
- ☐ **Two Measles, Mumps and Rubella** (MMR) - **Required if born on or after 1/1/1957** Physician/Clinic documentation of illness or documentation of two-dose vaccine series since age 12 months **or** proof of immunity
- ☐ **Varicella** (Chicken Pox**)** – **Required**. Documentation of 2 doses of varicella vaccine given at least 28 days apart, laboratory evidence of immunity, laboratory confirmation of disease, or diagnosis or verification of a history of varicella or herpes zoster (shingles) by a healthcare provider.
- ☐ **Annual Influenza Vaccine or** provide medical reason for not receiving vaccination (if no vaccine must wear mask in patient care areas). This is **required** during influenza season as determined by the Iowa Department of Public Health
- ☐ **Hepatitis B – Strongly recommended** for all employees who come in contact with blood or blood products. Physician/Clinic documentation of three-dose vaccine series **or** proof of immunity
- ☐ **Pertussis** (Whooping Cough) – **Strongly recommended** for all employees that have direct patient contact. Physician/Clinic documentation of vaccination (Tdap)

## EMT Student Background Check Release Form

Please complete and sign the **first page** of this Employment Reference/Background Check Release to expedite the processing of your application. **Birth date information will be used only for this purpose and will not be considered relevant to the hiring decision.**

I _____ _____ _____

**First** **Middle (required)** **Last**

**(Name as it appears on your social security card**)

I have applied for the EMT Class with Mary Greeley Medical Center. I certify that the information that I have provided is true and correct to the best of my knowledge and belief. I authorize Mary Greeley Medical Center to investigate my employment and personal history, including an inquiry concerning information on my criminal, child or dependent adult abuse and driving history, if appropriate. In connection with this investigation, I authorize all corporations, companies, educational institutions, persons, law enforcement agencies and former employees to release information that they may have about me and release them from any liability or responsibility from doing so. This authorization, in original or copy form, shall be valid for this and any future investigation conducted by Mary Greeley Medical Center. I am aware that if I am denied employment based on a report by a consumer-reporting agency, that Mary Greeley Medical Center will furnish the name and address of such agency upon my written request. I understand that any information will be held in strict confidence except as allowed by law.

Prior Name(s) (if applicable: Other last names including maiden name, alias)_____

☐ Check here if no prior names

Driver's License Number _____ Driver's License State _____

Social Security #:_____Date of Birth: _____

Current Street Address: _____City: _____

State: _____Zip: _____

☐ Please check here if you have lived outside of Iowa in the past seven years

**Please list all previous addresses that you have resided at in the past seven years:**

City: _____State: _____Zip: _____

City: _____State: _____Zip: _____

City: _____State: _____Zip: _____

City: _____State: _____Zip: _____

City: _____State: _____Zip: _____

**Signature**: _____Date: _____