

**Western Virginia EMS Council  
New River Valley Training Center**



**Application Packet**

***Spring 2016  
Advanced EMT  
Program***

*6580 Valley Center Drive  
Radford, VA 24141  
Phone: 540-562-3482 • Fax: 206-202-1190*

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**TUITION COST FOR THIS PROGRAM IS CURRENTLY SET AT \$1350.00 contingent on funding support from OEMS. Should funding request not be available TUITION COST will increase to \$1426.50. Notification will be made as soon as the program is notified by OEMS. Tuition cost covers instruction, textbook, E-text, online testing and clinical tracking.**

**Testing Fees are: \$150.00 for Advanced EMT Practical testing in the summer (if testing at NRVTC scheduled test site.)**

**\*\*\*Tuition cost does not include the fee charged by National Registry for the written CAT examination\*\*\*\***

**To be successful in this program; students will need to be highly motivated and dedicated to the program.**

**Please be sure read through entire application, if you have any questions, please contact Mike Garnett: 540.562.3482**

# Application Instructions/Check List Spring 2016

## IMPORTANT - READ CAREFULLY

**APPLICANTS ARE NOT CONSIDERED FOR THE PROGRAM UNTIL ALL OF THE REQUIRED DOCUMENTATION HAS BEEN SUBMITTED TO THE NEW RIVER VALLEY TRAINING CENTER  
WVEMS COUNCIL REGIONAL PROVIDERS ARE GIVEN ADMISSION PREFERENCE.**

***The following items are required to qualify for the entrance examination to the EMT-Intermediate program.***

- Review the **Admission Policy and Enrollment Requirements**
- Complete the **ENTIRE ALS Course Application**.
- Submit the **ALS Course Application** to the New River Valley Training Center, c/o Mike Garnett. Submission of the following items and completion of entrance exam, are to be no later than the **deadline of close of business on Friday, January 15th, 2016**
- Scheduled a date to take your **entrance examination and interview**. Call 540-562-3482 to select an available date and time.

***The following items are required to complete the ALS application package for the program. .***

- Copies of the following:
  - a. Driver's license/other Government issued photo ID
  - b. High school diploma OR General Equivalency diploma OR evidence of post-secondary education.
  - c. Current CPR card.\*  
**\*The current CPR courses which are accepted by the Virginia Office of EMS to meet these standards are:**
    - American Heart Association - Basic Cardiac Life Support - "Healthcare Provider"
    - American Red Cross - "CPR/AED for the Professional Rescuer and Healthcare Provider" or CPR/AED for Lifeguards
    - American Safety and Health Institute - "CPR-PRO"
    - Emergency Care and Safety Institute "Professional Rescuer"
    - Medic First Aid - BLS for Professionals "BLSPRO"
    - National Safety Council - "Healthcare and Professional Rescuer"
    - ProCPR - "Healthcare Provider"
  - d. VAOEMS EMT certification card
- Completed **Recommendation for ALS Program** form. Recommendation forms must be completed by your agency chief operational/training officer and endorsed by your agency Operational Medical Director.

***The following item should be completed and submitted to the Infectious Disease Coordinator by The beginning of lab sessions.***

- Complete the **Personal Health History Form** or submit copies of all information requested in lieu of the Personal Health History Form. This form is not required during the application process.

***During the week of January 17th, 2016 applicants to the program will be emailed notification and advised if they have been accepted into the program. Tuition must be paid by January 26<sup>th</sup>, 2016. Emergency services agencies or other organizations can be invoiced for the tuition. Students who are delinquent in payment of the course fees will be subject to dismissal from the program.***

# Admission Policy and Enrollment Requirements

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The WVEMS New River Valley Training Center will not discriminate in its admission policies on the basis of sex, race national origin, color, creed, disabling conditions, handicaps, age, religion or sexual preference. All applicants must meet the minimum requirements and provide documentation prior to entry into an Advanced Life Support program. Qualified applicants will be subject to a selection process by the NRV peer review committee.

Applicants must provide documentation of minimum requirements prior to entry into the Advanced EMT program.

## For entrance into all programs:

1. The applicant must meet the minimum requirements specified in the Virginia Emergency Medical Services Regulations section **12 VAC 5-31-1460, ALS student requirements.**
2. The applicant must hold a current and approved certification in CPR.
3. Applicants affiliated with an EMS agency in Planning District 4 (NRV) will be given first preference.
4. Applicants affiliated with an EMS agency in the Western Virginia EMS Council Region will be given second preference.
5. Applicants affiliated with an EMS agency outside of the Western Virginia EMS Region will be given third preference.
6. Non-affiliated applicants will be considered, if space is still available after all affiliated applicants.
7. The applicant shall complete an EMT-Basic knowledge entrance examination and must achieve a satisfactory score of 70 or greater to be considered. The applicant will have one opportunity to successfully complete this exam

## 12 VAC 5-31-1460. ALS student enrollment requirements.

An enrolled student in an ALS certification program shall comply with the following:

1. Be proficient in reading, writing and speaking the English language in order to clearly communicate with a patient, family or bystander to determine a chief complaint, nature of illness, mechanism of injury, to assess signs and symptoms and interpret protocols.
2. Be a minimum of 18 years of age at the beginning date of the certification program.
3. Certification as an EMT or higher EMS certification level.
4. Possess a High school or general equivalency diploma.
5. Have no physical or mental impairment that would render the student or provider unable to perform all practical skills required for that level of certification, including the ability to function and communicate independently and to perform appropriate patient care, physical assessments and treatments.
6. If in a bridge certification program, the student shall be eligible for certification at the prerequisite lower ALS level at the beginning date of the bridge program and shall have obtained certification at the bridge program's prerequisite certification level before certification testing for the bridge level.

## GENERAL COURSE POLICIES:

1. No more than **15% of required course hour's** absence is allowed in this program for any reason (for the overall program.) A memo will be distributed the first night of class explaining this further. Students missing more than the maximum hours allowed will be dropped from the course.
2. All Students must maintain at least a 70% average overall for the course to be considered passing to be allowed to continue in the program and for student participation in any and all certification processes.
3. All students must consent to a criminal history and drug screening in order to participate in clinical and field externship components of the program. Starting and completing any clinical or field rotations, and thus completion of the program, is contingent upon a **NEGATIVE** drug screen for specified substances. Confidentiality will be maintained at all times in accordance with WVEMS Council Student Drug Testing Policies.

**ALL STUDENTS WILL SIGN A WAIVER EXPLICITLY STATING THAT PROHIBITING A STUDENT FROM STARTING AND/OR COMPLETING CLINICAL OR FIELD EXTERNSHIP ROTATIONS WILL NOT BE CONSIDERED IN AND OF ITSELF A VIOLATION OF STUDENT CONFIDENTIALITY.**

4. All students **must** document the enclosed health information listed on the medical documentation forms. Documentation of all immunizations must be submitted to the program's designated infection control officer on a date specified prior to the beginning of laboratory sessions.
  - A. Proof of immunization or results of rubella (German measles) titer. **(Required.)**
  - B. Proof of immunization or results of mumps titer. **(Required.)**
  - C. Proof of immunization or results of rubeola (measles) titer. **(Required.)**
  - D. Proof of flu vaccination. **(Recommended.** Students who do not receive the flu vaccination will be required to wear a mask at all times during clinical rotations.)
  - E. Hepatitis B vaccine status. **(Recommended.** If vaccination is declined, a declination form must be supplied or completed.)
  - F. Proof of immunization or results of varicella titer, if there is no history of chicken pox. (If you have had chicken pox, submit documentation from your health care provider attesting to the history of the disease.)
  - I. Results of tuberculin skin test (TST). Two-step TST is required if you do not have a documented negative TST result during the preceding 12 months. If you have a documented negative TST result during the preceding 12 months, you need only complete one-step TST  
A TB blood test (QuantiFERON®-TB Gold Test) may be substituted for the tuberculin skin test.
5. All students **must** submit a signed **NOTICE OF DEEMED CONSENT TO INFECTIOUS DISEASE BLOOD TESTING** form, along with a completed and signed **SPONSORING AGENCY ACCEPTANCE OF FINANCIAL RESPONSIBILITY FOR INFECTIOUS DISEASE TESTING** form.
6. Students must successfully complete **all** aspects of the program (classroom, clinical and field internship). It is especially important to understand that you must attain the **minimum required number of all** clinical "competencies" to complete the program.

**PLEASE KEEP THESE GENERAL COURSE POLICIES, DO NOT RETURN WITH THE APPLICATION!**

**TO BE READ AND SIGNED BY APPLICANT**

I have read the attached Advanced Life Support Training Programs Course Requirements and understand the requirements and meet all of those listed and applicable.

**I UNDERSTAND THAT COMPLETION OF THIS APPLICATION DOES NOT GUARANTEE ADMISSION TO THE COURSE. I FURTHER UNDERSTAND THAT THE PEER REVIEW COMMITTEE MAKES CLASS SELECTIONS AND THAT THEIR DECISION AND THAT OF THE PHYSICIAN COURSE DIRECTORS ARE FINAL.**

I understand that I must consent to criminal history check and drug screening in a manner specified by the WVEMS New River Valley Training Center by the deadline established for the course in order to participate in clinical and field externship components of the program. Starting and completing any clinical or field rotations, and thus completion of the program, is contingent upon a NEGATIVE drug screen for specified substances. Confidentiality will be maintained at all times in accordance with WVEMS Council Student Drug Testing Policies.

**I UNDERSTAND THAT I MUST SIGN A WAIVER EXPLICITLY STATING THAT PROHIBITING ME FROM STARTING AND/OR COMPLETING CLINICAL OR FIELD EXTERNSHIP ROTATIONS WILL NOT BE CONSIDERED IN AND OF ITSELF A VIOLATION OF CONFIDENTIALITY.**

Program completion is defined as completing all program requirements necessary to qualify for certification examination.

I agree to be responsible for any additional course fees if they become necessary. No refunds will be made after the second class. Practical exam cancellations, if necessary, must be made no later than the close of business 10 days prior to the practical exam.

I also understand that completion of this course does not guarantee that I will be allowed to participate in any certification processes. That decision is at the discretion of the Program Director, Program Coordinator and the Physician Course Director.

I hereby affirm that the information I have submitted on this application is true and correct and I realize that any fraudulent entry may be considered sufficient cause for rejection or subsequent revocation. I further affirm that I am eligible for certification as a Virginia EMS provider under **12 VAC 5-31-910** (criminal or enforcement history) of the Virginia EMS Rules and Regulations.

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Signature of Applicant

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Date

# Course Application:

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## Section-1: APPLICANT INFORMATION [PLEASE PRINT CLEARLY]

_____ Last Name	_____ First Name	_____ MI	_____ Certification Number	_____ Expires
_____ Street Address				
_____ City/Town	_____ State	_____ Zip Code	_____ Phone (Home)	
_____ E-mail address			_____ Phone (Alternate – <i>specify type</i> )	
_____ EMS Agency Affiliation			_____ Date of Birth	

## Section-2: IN CASE OF EMERGENCY, PLEASE NOTIFY [PLEASE PRINT CLEARLY]

_____ Last Name	_____ First Name	_____ MI	_____ Relationship	
_____ Street Address			_____ Phone (Home)	
_____ City/Town	_____ State	_____ Zip Code	_____ Phone (Alternate – <i>specify type</i> )	

## Section-3: AFFIRMATION AND SIGNATURE

I certify that I meet all requirements of the New River Valley Training Center and the Virginia Office of Emergency Medical Services, which are necessary to enroll in this course.

_____ Signature	_____ Date
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## Section-4: ENTRANCE EXAMINATION DATE

Enter the date you will take the entrance examination: \_\_\_\_\_

# Personal Health History

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Every student entering an advanced life support program at the WVEMS New River Valley Training Center is required to return this record, properly completed to WVEMS New River Valley Training Center. If you have any physical or emotional impairment that may require accommodations at the WVEMS New River Valley Training Center, please indicate these under the Pertinent Health Information section below so that we may make plans to meet your needs.

***Students will not be permitted to participate in field or clinical sessions until this information has been provided.***

**Completely fill out all information below. [PLEASE PRINT CLEARLY]**

_____	_____	_____		
Last Name	First Name	MI		
_____	_____	_____	_____	_____
Street Address	City/Town	State	Zip Code	
_____	_____			
Phone Number	E-mail address (if available)			
_____				
Program of Study				

## Pertinent Health Information

Please list any disabilities, special needs, allergies or required medication that you would like the New River Valley Training Center to be aware of:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The information given on this form is correct to the best of my knowledge. I authorize the WVEMS New River Valley Training Center to contact the health professional for verification or clarification of information contained on this form.

_____	_____
Student Signature	Date
_____	
Print Name	

**IMMUNIZATION RECORD**

Complete and return this form. Attach additional sheets of paper if more space is required. Immunization records may be submitted in the absence of the signature of a health care provider if a copy of the medical record documenting each immunization, procedure or titer is attached to this form.

**MMR (Measles, Mumps, Rubella)**

- Immunization Dose 1..... Date: \_\_\_\_\_
- Immunization Dose 2..... Date: \_\_\_\_\_

**RUBEOLA (Measles) – If given instead of MMR. Check appropriate boxes.**

- Immunization Dose 1..... Date: \_\_\_\_\_
- Immunization Dose 2..... Date: \_\_\_\_\_
- Report of immune titer..... Date: \_\_\_\_\_
- Documentation of diagnosed measles disease..... Date: \_\_\_\_\_

**MUMPS – If given instead of MMR. Check appropriate boxes.**

- Immunization Dose..... Date: \_\_\_\_\_
- Report of immune titer..... Date: \_\_\_\_\_
- Documentation of diagnosed mumps disease..... Date: \_\_\_\_\_

**RUBELLA (German Measles) – If given instead of MMR. Check appropriate boxes.**

- Immunization Dose..... Date: \_\_\_\_\_
- Report of immune titer..... Date: \_\_\_\_\_

**VARICELLA (Chicken Pox) – Check appropriate boxes.**

- Varicella vaccine..... Date: \_\_\_\_\_
- Serologic evidence of immunity..... Date: \_\_\_\_\_
- Reliable history of chicken pox..... Date: \_\_\_\_\_

**TUBERCULOSIS – Check appropriate boxes.**

*Two-step TST is required if the student does not have a documented negative TST result during the preceding 12 months. If the student has a documented negative TST result during the preceding 12 months, only complete one-step TST. A TB blood test (Quantiferon®-TB Gold Test) may be substituted for the TB skin test.*

- TB Skin Test: \_\_\_\_\_ mm of induration (first or previous test) Date: \_\_\_\_\_
- TB Skin Test: \_\_\_\_\_ mm of induration (second test) Date: \_\_\_\_\_
- TB Blood Test: *Result of test:* \_\_\_\_\_ Date: \_\_\_\_\_
- Results of chest x-ray if TB testing is positive: \_\_\_\_\_ Date: \_\_\_\_\_  
*Chest x-ray may be substituted for a TB testing if x-ray taken within the past year.*

**HEPATITIS-B – Check appropriate boxes.**

- Hepatitis-B Series.....
 

<b>Dose 1</b>	<b>Dose 2</b>	<b>Dose 3</b>
____ / ____	____ / ____	____ / ____
Month      Year	Month      Year	Month      Year
- Has not completed Hepatitis-B series.

**Seasonal Flu Vaccine – Check appropriate boxes.**

- Flu Vaccine Received ..... Date: \_\_\_\_\_

Health Care Provider Signature (Physician or RN)	Name (Print) / Credential	
Address		Date

