MIAMI DADE COLLEGE
MEDICAL CAMPUS
SCHOOL OF HEALTH SCIENCES
EMERGENCY MEDICAL TECHNICIAN (EMT) PROGRAM APPLICATION

_____ _____
Student Name (Print) Student Number

Email address: _____

Class Preference:	
	Medical Campus, Monday & Wednesday: 5:00 PM – 9:00 PM
	Medical Campus, Tuesday & Thursday: 5:00 PM – 9:00 PM
	Homestead Campus, Tuesday & Thursday: 6:00 PM – 10:00 PM
	Medical Campus: 9:00 AM – 1:00 PM (Days vary by semester)

APPLICATION REQUIREMENTS:

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THE APPLICATION TO BE ACCEPTED AND/OR REGISTERED FOR THE CLASSES ASSOCIATED WITH THE PARAMEDIC PROGRAM. IT IS THE STUDENT'S RESPONSIBILITY TO PROVIDE ALL COPIES OF REQUIRED INFORMATION, HEALTH DOCUMENTATION, AND CRIMINAL BACKGROUND VERIFICATION.

REQUIRED ITEMS/INFORMATION	
	COPY OF FIRST RESPONDER CERITIFICATE OR EQUIVALENT
	COPY OF CURRENT CPR CERTIFICATION, BLS FOR HEALTH CARE PROVIDERS
	COPY OF JACKSON MEMORIAL HOSPITAL (JMH) ORIENTATION
	COMPLETED STUDENT HEALTH RECORD FORM (must be included with extra copy of form and lab tests results)
	Documentation of Influenza Shot and Hepatitis B Vaccine Series
	Documentation of a titer results for Varicella, Mumps, Rubella, and Rubeola
	Documentation of a 10-panel drug screen test
	Documentation of TWO (2) TB skin Tests/or QuantiFERON test [performed within the last three (3) months]
	Documentation of Tdap (Tetanus, Diphtheria, Pertussis) Vaccination within the last TEN (10) years
	Signature of the health care examiner
	COPY OF PERSONAL MEDICAL INSURANCE CARD
	COPY OF LETTER OF COMPLETION OF THE CRIMINAL BACKGROUND CHECK FROM THE DESIGNATED BACGROUND CHECK PROVIDER. ***Student must submit a copy of the BACKGROUND CHECK FROM THE DEAN'S DEPARTMENT (Room 1355) verifying completion of the criminal background to satisfy this requirement.***
	PROOF OF ACCEPTABLE PERT SCORES OR EQUIVALENT
(STAFF USE ONLY) Date Received: _____ Initials: _____	

Miami Dade College
Medical Campus

MIAMI DADE COLLEGE

MEDICAL CAMPUS
Student Health Record Form

Name: _____ **Student Number:** _____
Last **First** **Middle Initial**

I understand that student health information is protected and confidential under State of Florida and federal laws. I voluntarily provide, and consent to my medical provider or physician providing, the medical information contained in this document to the Miami Dade College and health care facilities that I am assigned to as part of Miami Dade College's medical program requirements. I also understand that all requested Student Health Record information is a prerequisite to enrollment in the clinical training of any Medical Center Campus program. Failure to complete this record will prevent my participation in the clinical training. The student and Health Care Examiner (MD, DO, PA, ARNP) must sign in the appropriate spaces provided on the form. **Documentation of all titers, vaccines, drug screening, TB testing, and x-rays must be attached to the student health record.**

SECTION 1: PERSONAL INFORMATION
All areas of this section must be completed. This information will be kept on file and used in the event that the student must be contacted or an emergency contact is required.

SECTION 2: REQUIRED INFLUENZA INJECTION (FLU SHOT)
Students participating in a clinical rotation must receive the influenza injection. Students that cannot participate in the influenza injection process as a result of a medical condition or refuse to participate in the influenza injection may be required to participate in additional measures established by a clinical site. Additionally, it may jeopardize the student's ability to participate in the clinical portion of a Medical Campus program. It is highly recommended that all students receive the influenza injection.

SECTION 3: REQUIRED TITERS/TESTS

A. **Varicella (Chicken Pox):** A Varicella Titer must be drawn and ***the results attached.*** **A record of the Varicella Vaccine will not be accepted as documentation of the required titer.** The date of the titer and results must be indicated in the appropriate area. ***(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).***

Mumps, Rubeola (Measles), and Rubella (German Measles): A Mumps, Rubeola, and Rubella Titer must be drawn and ***the results attached.*** A **record of the MMR (Mumps, Measles, Rubella) Vaccine will not be accepted as documentation of the required titer.** The dates of the titers and the results must be indicated in the appropriate area. ***(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).***

B. **TB Skin Test:** Two consecutive TB Skin Tests are required. The TB Skin tests can be repeated a minimum of seven days apart. ***The dates and results of each TB Skin Test must be attached.*** The Skin Tests must have been performed within the last three (3) months to be considered a recent test. Results from QuantiFERON are acceptable within the last three (3) months.

Chest X-ray: A recent Chest x-ray is required if a positive TB skin Test or QuantiFERON is reported or there is a history of a positive TB Skin Test. The chest x-ray must have been completed within the last three (3) months to be considered current. ***Results must be attached.***

C. **Drug Screening:** A minimum of a 10-panel drug screen is required. A second drug screen test may be required by some health care facilities. ***A positive result on this test will result in the student's inability to participate in the clinical portion of any Medical Campus program at Miami Dade College.*** **The results must be indicated and attached.**

Section 4: Hepatitis B Vaccine
Students must provide documentation of the initiation or completion of the Hepatitis B vaccine series at the time of application. It is highly recommended that the student completes the series while enrolled in the program. Further information of the Hepatitis B Vaccine is provided on the Student Health Record Form on page 3. **The results must be attached.**

Section 5: Tdap (Tetanus, Diphtheria, Pertussis) Vaccination
Students must provide documentation of the Tdap vaccination within the last ten (10) years.

Section 6: Student's Statement
Student must read and sign this statement on page 3 of the Student Health Record.

Section 7: Examiner's Statement
The Health Care Examiner (MD, DO, PA, and ARNP) must read, sign, and confirm that the student can meet the Physical Demands associated with the program in the Examiner's Statement Area on page 4 of the Student Heath Record.

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

SECTION 1: PERSONAL INFORMATION

_____ Apt.#_____ _____
Address E-mail address
_____ _____ _____ Gender: M ____ F ____
City State Zip Code
_____ / _____ / _____ _____ _____ _____
Date of Birth Last four of SS# Home Telephone Number Cellular Phone Number
_____ _____ _____
Person to Notify in Emergency Relationship Contact Telephone Number

SECTION 2: INFLUENZA INJECTION (Documentation must be attached)

Date of injection: _____
I understand that if I cannot participate in the influenza injection process as a result of a medical condition or refuse to participate in the influenza injection, I may be required to participate in additional measures established by a clinical site. Additionally, it may jeopardize my ability to participate in the clinical portion of a Medical Campus program.

STUDENT SIGNATURE: _____ DATE: _____

SECTION 3: REQUIRED TITERS/TESTS

Parts A, B, C: THESE BOXES ARE TO BE COMPLETED BY AUTHORIZED MEDICAL PERSONNEL ONLY

A. REQUIRED TITERS: (Documentation must be attached)

A Varicella (Chickenpox), Mumps, Rubeola (Measles), and Rubella (German Measles) Titer must be drawn and the results attached. ***A record of Vaccines WILL NOT BE ACCEPTED as documentation for the required titers.*** The dates of the titers and the results must be indicated in the appropriate area below. ***(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).***

TITER	DATE	LAB RESULTS (Documentation must be attached) (Numerical Value of Results Must Be Reported Below)	Please Circle
Varicella (Chickenpox) Titer	_____/_____/_____ Month Day Year		**Immune/ Not Immune**
Mumps Titer	_____/_____/_____ Month Day Year		**Immune/ Not Immune**
Rubeola (Measles) Titer	_____/_____/_____ Month Day Year		**Immune/ Not Immune**
Rubella (German Measles) Titer	_____/_____/_____ Month Day Year		**Immune/ Not Immune**

B. TB SKIN TEST/ QUANTIFERON /CHEST X-RAY

Two consecutive TB Skin Tests are required. ***The TB Skin tests can be repeated a minimum of seven days apart***. The dates and results of each TB Skin Test must be attached. The Skin Tests must have been performed ***within the last three (3) months*** to be considered a recent test. Results from QuantiFERON are acceptable. **In the event the results indicate a positive skin test or QuantiFERON, or the student has a history of a positive TB skin test, a chest x-ray is required. The chest x-ray must have been completed within the last three (3) months to be considered current. Results must be attached.**

TEST	DATE	RESULTS	
TB Skin Test **1st Test**	____/____/____ **Month Day Year**	**Positive _____ Negative_____**	**If positive skin test, current chest x-ray is required. *Results of TB skin test must be attached.***
TB Skin Test **2nd Test**	____/____/____ Month Day Year	**Positive _____ Negative_____**	**If positive skin test, current chest x-ray is required. *Results of TB skin test must be attached.***
QuantiFERON	____/____/____ Month Day Year	**Positive _____ Negative_____**	**If positive, current chest x-ray is required. *Results of QuantiFERON must be attached.***

Chest X-ray	____/____/____ Month Day Year	**Positive _____** **Negative_____**	***RESULTS OF CHEST X-RAY MUST BE ATTACHED***

C. DRUG SCREENING

A **minimum** of a 10-panel drug screen is required. *A positive result on this test will result in the student's inability to participate in the clinical portion of any Medical Campus program at Miami Dade College.* The results must be indicated and attached.

TEST	DATE	RESULTS	
Drug Screen **(10 Panel)**	____/____/____ Month Day Year	**Positive _____** **Negative_____**	***A positive result on this test will result in the student's inability to participate in the clinical portion of any Medical Center Campus program at Miami Dade College. RESULTS OF 10 Panel DRUG SCREEN TEST MUST BE ATTACHED.***

SECTION 4: HEPATITIS

Introduction: Health care professionals are at risk of exposure to blood and body fluids contaminated with the viruses that cause HIV and Hepatitis. Consistent use of Standard Precautions is the best-known means to avoid transmission of these viruses or other contaminants. Students will be taught Standard Precautions before they provide care to any patient in the clinical setting. Although it is rare, a health care worker may become exposed to one of these viruses through accidental transmission. Currently, there is no vaccine that protects against the HIV virus. However, the Hepatitis B vaccine is an effective means of preventing Hepatitis B. As a student who will be providing direct patient care, you should discuss this vaccine with your health care provider.

About the Vaccine: The Hepatitis B Vaccine is a genetically engineered "yeast" derived vaccine. It is administered in the deltoid muscle (arm) in a series of three doses over a six-month period. You should seek additional information about the vaccine from your health care provider; especially if you have an allergy to yeast or may be pregnant, or are a nursing mother.

I have initiated the Hepatitis B Vaccine Series with my first dose listed below: **(ATTACH COPY OF DOCUMENTATION)**

1st Dose: Date: ____/____/____ 2nd Dose: ____/____/____ (One month after 1st dose) 3rd Dose: ____/____/____ (Six months after 1st dose)

OR

I have already completed a Hepatitis B Vaccine Program with dates of injections listed below: **(ATTACH COPY OF DOCUMENTATION)**

1st Dose: Date: ____/____/____ 2nd Dose: ____/____/____ (One month after 1st dose) 3rd Dose: ____/____/____ (Six months after 1st dose)

OR

Antibody testing has revealed that I have immunity to Hepatitis B. Yes _____ No _____
(ATTACH COPY OF LAB REPORT).

SECTION 5: Tdap (Tetanus, Diphtheria, Pertussis) Vaccination

Students must provide documentation of the Tdap vaccination within the last ten (10) years.

Received: ____/____/____ **(**ATTACH COPY OF DOCUMENTATION)
Month Day Year

SECTION 6: STUDENT'S STATEMENT

In order to satisfy medical program requirements, I hereby consent to the release and disclosure of my personal health information provided on the **Student Health Record Form** to Miami Dade College and any health care facility in which I am assigned for on-site clinical training. I understand that my personal health information is required to facilitate my participation in the clinical training, which is required for program completion. I also hereby release and hold harmless Miami Dade College and receiving health care facilities from any claim of violation of HIPAA or any other medical privacy rights that may arise for the release of my personal health information provided in the **Student Health Record Form**.

Print Name: _____

Student Signature: _____ Date: _____

PHYSICAL DEMANDS

In order to fulfill the requirements of the EMS Program at Miami Dade College, students must be able to meet the physical demands associated with the profession. Examples of these requirements include but are not limited to the following:

Code: F = frequently O = Occasionally NA = Not Applicable

Physical Demands	Code	Comments
Standing	**F**	
Walking	**F**	
Sitting	**O**	
Lifting (up to 125 pounds)	**F**	
Carrying	**F**	
Pushing	**F**	
Pulling	**F**	
Balancing	**F**	
Climbing	**F**	
Crouching	**F**	
Crawling	**F**	
Stooping	**F**	
Kneeling	**F**	
Reaching	**F**	
Manual Dexterity	**F**	
Feeling	**F**	
Talking	**F**	
Hearing	**F**	
Seeing	**F**	
Communicating	**F**	

(For specific Performance Standards associated with the EMS Program please contact the Program Coordinator at 305-237-4337).

Limitations: _____

_____

SECTION 7: EXAMINER'S STATEMENT

I have verified that the individual I have examined is the named individual on this document and that the information about the test results are correct. This individual can participate in all activities required to provide health care to patients in an acute or chronic care facility, emergency setting or any other situation that is part of the learning experiences in the designated health care program. The student is able to meet THE PHYSICAL DEMANDS that are listed above. **(List any limitations associated with this student in the area provided).**

_____ _____

MD/DO/PA/ARNP Signature Date

_____ _____

Office Telephone Number License Number

MIAMI DADE
COLLEGE MEDICAL
CAMPUS

CRIMINAL HISTORY INFORMATION CHECKS REQUIRED FOR MEDICAL CAMPUS PROGRAM STUDENTS

Florida law requires level 2 criminal background screenings for "all employees in position of trust or responsibility", pursuant to §435.04, Florida Statutes (2004). The Joint Commission of Accreditation of Healthcare Organizations (JCAHO), a healthcare accreditation entity, also requires healthcare facilities to conduct background screenings on employees, students, and volunteers in accordance with state law and regulation and/or the internal procedures of the healthcare facility. The purpose of the level 2 criminal background screenings, which include fingerprinting and a state and federal criminal records check, is to ensure patient safety and maintain trust and integrity within the healthcare professions.

Many of the College's healthcare training facilities now require the College to conduct level 2 criminal background screenings on all faculty, students and any other person who participates in clinical training at a healthcare facility. In response to this requirement, all faculty, students or any other persons that participate in the College's clinical training programs are required to obtain a level 2 criminal background screening before beginning their participation or continuing their participation in any of the College's clinical placement programs. In most instances, previous screenings are not accepted by the College.

To obtain the level 2 background check for your enrollment in your selected program at Miami Dade College, students should do the following:

1) Schedule an appointment at http://ibrinc.com/mdc/select

2) Follow the link identified as "Medical Campus Student/Health Sciences".

3) Complete the requested information for the completion of the background check process.

4) The background check process could take 3-7 business days to complete.

5) Contact the Dean's Department to pick up copy of background check in Room 1355 at the Medical Campus. Please call 305-237-4028 to verify receipt of background check.

MIAMI DADE
COLLEGE MEDICAL
CAMPUS

ACKNOWLEDGMENT AND CONSENT FOR RELEASE OF INFORMATION

I understand that placement in a clinical setting is an essential component of my education in a health science program offered by the Medical Campus of Miami Dade College.

I have been informed that many healthcare agencies require a level 2 criminal background screening as a prerequisite for placement in an agency. I hereby consent to Miami Dade College receiving the results of my level 2 criminal background screening. I also understand that this information will be held confidential by the College and will not become a part of my student record. I give the College permission to disclose and/or share the results of the screening with a clinical agency for the sole purpose of clinical placement eligibility within a clinical agency.

I acknowledge that the clinical agency may make the determination, regarding specific criminal charges, that would disqualify me from participating in a clinical program, and that Miami Dade College is not involved in, and has no control over, that determination. I understand that if I am disqualified from participating in the clinical program as a result of the criminal background screening, I may not be permitted to continue in the Medical Campus program in which I am enrolled.

I hereby sign this form voluntarily with the understanding that a level 2 criminal background check is a prerequisite to clinical placement in a Miami Dade College Medical Campus program.

Name:_____

Date of birth:_____Student Number: _____

Medical Campus Program _____

I have worked, resided or been a student in a state other than Florida, or a country other than the United States, during the past 24 months:

Yes_____No_____.

If yes, name of state or country:

_____

Student Signature

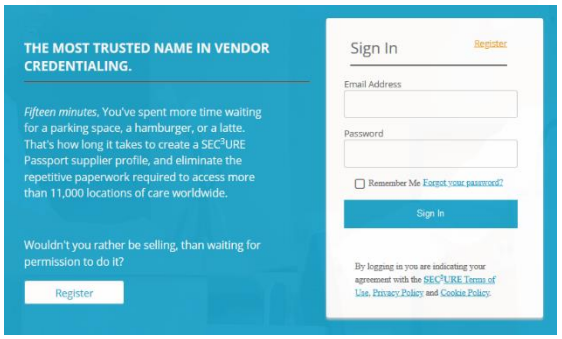
Please be advised:

Students registering for the EMT Program students must complete and print out the JMH online orientation at:
https://www.jhsmiami.org/orientation/
Failure to complete this orientation will hinder the registration process.

To access the JMH orientation confirmation page:

1. Create JMH (student) account
2. Log in to your JMH (student) account
3. Click on My Tests
4. Once there in the upper right corner click on view/print transcript and page will generate that has your name on top. On the left side of the page green check marks will appear. On the right side with the number and name of the online class completed will appear. The account type (which should say student) and the completion date of orientation will appear in the middle.

Student Registration for IntelliCentrics SEC³URE Account



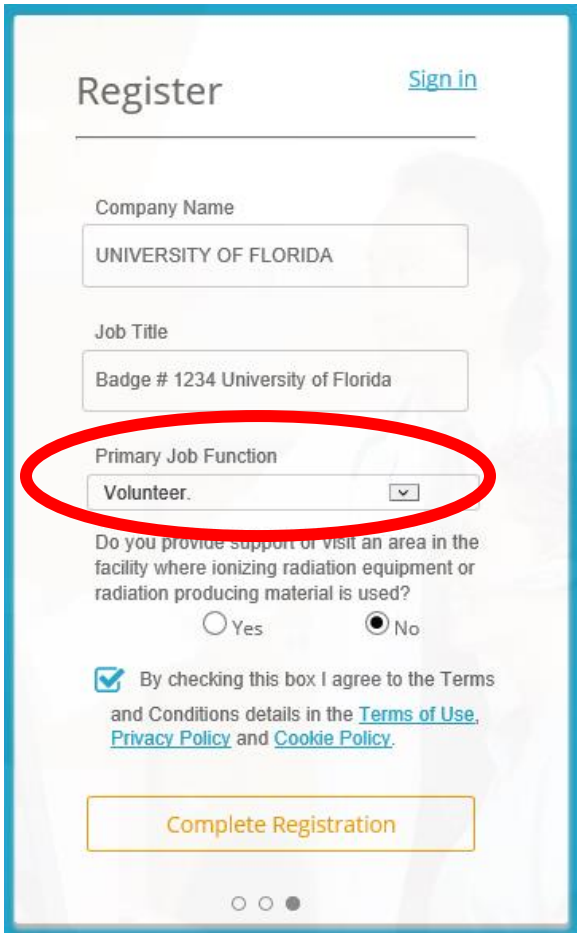
All students are required to create an account in the IntelliCentrics SEC³URE platform. Follow the information below to set-up your account. You are required to have a unique email address for logging into the system as well as a head shot (head and shoulders picture) you will attach to your account.

Students must provide proof of registration when submitting selection packet to MDC Medical. This account allows you to check-in at the vendor kiosks when you arrive at any Jackson Health hospital. Once your account is created, send an email to Nursing-Affiliation@JHSMiami.org and include your Name, Email Address and Unique assigned ID number to email. (This number is found in the upper right-hand corner of the screen.)

The following process will be observed.

1. Register for an account at www.sec3ure.com
2. Complete the data fields using the format below
3. Choose Volunteer as your primary job function
4. Complete your account details
5. Add your facilities

Company Name	**Miami Dade College**
Job Title	**Badge # - Student at 'Add your School Name'**
Primary Job Function	**Choose Volunteer**
Account Details	**COMPLETE THE INFORMATION BELOW**
Manager Name	**Jesus Sola**
Manager Phone	**305-237-4489**
Manager Email	**jsola@mdc.edu**



Add your facilities by clicking on the 3 horizontal lines then click

My Account > Facilities > Add New Facility > Select State > Find Facility > Check your facility > Add Selected

6. Send a confirmation of your SEC3URE Account to Nursing-Affiliation@JHSMiami.org. Be sure to include your Name, Email address and Unique ID in the email. Please let us know if you have any questions regarding our program.

Thank you,

Jackson Health Staff

Miami-Dade Fire Rescue Department
Office of the Fire Chief
9300 NW 41st Street
Doral, Florida 33178-2414
T 786-331-5000 F 786-331-5101

miamidade.gov

MIAMI-DADE FIRE RESCUE DEPARTMENT
REQUEST FOR PERMISSION TO PARTICIPATE (OBSERVER/RIDER)
HOLD-HARMLESS AGREEMENT

THE UNDERSIGNED (PARTICIPANT), being eighteen years of age or older, does hereby request the Miami-Dade Fire Rescue Department of Miami-Dade County, Florida, to allow the aforementioned to observe fire rescue and emergency service procedures, techniques, or practices by an authorized representative of the Miami-Dade Fire Rescue Department at an authorized facility, in a practical field environment, or in an authorized Miami-Dade Fire Rescue Department vehicle. If permission is granted, I hereby agree to always obey all instructions, orders and commands given to me by the officer or officers in command of the training or instruction exercise. (If under eighteen years of age complete section 2-YOUTH).

I FULLY REALIZE AND APPROCIATE THE BASIC NATURE OF FIRE RESCUE AND EMERGENCY SERVICE WORK AND THE POSSIBILITY THAT SITUATIONS WILL ARISE WHICH MIGHT RESULT IN MY BEING EXPOSED TO DANGER INCLUDING, BUT NOT LIMITED TO, INFECTIOUS DISEASES, MOTOR VEHICLE, AIRCRAFT, OR BOATING ACCIDENTS; ANY INTENTION OR NEGLIGENT ACTS OR OMISSIONS BY ME, OR ANY OFFICE, EMPLOYEE OR AGENT OF MIAMI-DADE COUNTY, OR MALFUNCTION OF EQUIPMENT USED DURING TRAINING OR INSTRUCTION.

THEREFORE; in consideration for the educational benefit to be received and the granting of the above request, I hereby agree to hold Miami-Dade County, its Board of County Commissioners, its employees, agents and servants harmless from all liability for property damage, physical harm, personal injury or death arising out of observing and riding rescue services, and I further agree to waive all rights or claims to damages, legal or equitable, arising out of any intentional , unintentional or negligent acts or omissions by me, or any officer, employee, or agent of Miami-Dade County, or a malfunction of any equipment used during observation ride(s).

Appropriate dress code for participants (observers/riders) will include dark colored slacks, dark colored flat shoes, and a white shirt/blouse or an identifiable uniform, such as military or nurse. Dress attire must be approved by the office in charge of the unit.

To comply with the **Federal HIPPA (Health Insurance Portability Accountability Act) Law**, Miami-Dade Fire Recue Department will not allow participants (observers/riders) to photograph, film, or participate in any other activity that may violate patient confidentiality.

This agreement shall remain in effect for every occasion on which the participant requests and is granted permission to receive training or instruction.

The undersigned acknowledges that this agreement has been read, understood, fully explained, and all questions regarding it have been answered.

_____ _____

PARTICIPANT'S PRINT NAME **PARTICIPANT'S SIGNATURE**

ADDRESS: _____

AGE: _____ **PHONE NUMBER:** _____

EMAIL ADDRESS: _____

ALS PRE HOSPITAL AFFILIATION: ☐ **YES** ☐ **NO**

MIAMI-DADE FIRE RESCUE DEPARTMENT
REQUEST FOR PERMISSION TO PARTICIPATE (OBSERVER/RIDER)
HOLD-HARMLESS AGREEMENT

SECTION 1

STATE OF FLORIDA
COUNTY OF _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this

_____ day of _____, 20_____by_____, who ☐ is personally

known to me or ☐ produced a _____ as identification, regarding the attached instrument described as **HOLD-HARMLESS AGREEMENT** and to whose signature whose notarization apply.

SEAL/STAMP

_____
NOTARY PUBLIC NAME

_____
NOTART PUBLIC SIGANTURE

SECTION 2

Must be completed by parents of youth under 18 years of age.

STATE OF FLORIDA
COUNTY OF _____

I certify that I am the parent or legal guardian of _____ who is under eighteen years of age. We have read and understand the-MIAMI-DADE FIRE RESCUE DEPARTMENT REQUEST FOR PERMISSION TO PARTICIPATE (OBSERVER/RIDER) HOLD-HARMLESS AGREEMENT-YOUTH and agree to allow our youth to participate as an observer/rider and to the terms and conditions set forth therein.

LEGAL GUARDIAN'S NAME: _____

LEGAL GUARDIAN'S SIGNATURE: _____ **DATE:** _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization, this

_____ day of _____, 20_____by_____, who ☐ is personally

known to me or ☐ produced a _____ as identification, regarding the attached instrument described as **HOLD-HARMLESS AGREEMENT** and to whose signature whose notarization apply.

SEAL/STAMP

_____
NOTARY PUBLIC NAME

_____
NOTART PUBLIC SIGANTURE