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The following items are required to participate in the upcoming Paramedic course

Please complete or return them to the office no later than 1 week prior to class

1. Active Florida EMT Certification	__ Copy Submitted
2. Program Application	__ Signed and Returned
3. Authorization for Background Check	__ Signed and Returned
4. Enrollment Agreement	__ Signed and Returned
5. Tuition Payment	__ Paid
6. Course Materials Receipt Form	__ Signed and Returned
7. Florida State Driver's Licenses	__ Copy Submitted
8. Social Security Card	__ Copy Submitted
9. High School Diploma/GED	__ Copy Submitted
10. *Valid Healthcare Provider Card (CPR-AHA)	__ Copy Submitted
11. Course Policy Signature Form	__ Signed and Returned
12. HH/SA/IR/DT/ ID Forms	__ Signed and Returned
(Hold harmless, substance abuse, information release, drug testing, infectious disease)	
13. Physician's Clearance Form	__ Copy Submitted
14. TB Test Result (within 12 month, can be noted on Physician's Clearance)	__ Proof Submitted
15. MMR Immunizations (can be noted on Physician's Clearance)	__ Proof Submitted
16. Hepatitis B Declination/Vaccination Form	__ Signed and Returned
17. Proof of 10 Panel Drug Screening	__ Proof Submitted

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Paramedic Program
Admission Requirements

Please bring in copies of documents

1. Completed program application and a non refundable application fee due at time application is submitted.
2. Must be at least 18 years of age.
3. Valid State of FL Drivers License and Social Security Card.
4. High School Diploma or G.E.D.
5. Florida Bureau of EMS EMT Certification (Active), Or Prior to completion of 300 hours of the Paramedic program.
6. Documentation of annual physical exam with the last 12 months and you must currently be in good physical health.
7. Documentation of current immunizations to include: MMR, TB within the last 12 months, Hepatitis B (optional).
8. Background check, which is non-refundable and is part of the application fee.
9. Pass a NCEMI basic entrance exam with a 60.
10. Approval by Program Director to be enrolled into program after background check is completed.
11. Valid AHA Healthcare Provider CPR card, for the duration of the class
12. Drug screening, cost is non-refundable and not part of application fee.
13. The total program cost of $6470.00. If you have any further questions, please feel free to contact me at (352) 249-4734 office, or (352) 400-1151 cell phone, or by email, ronaldb@naturecoastems.org.
    Ronald Bray EMT-P, CCP

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Paramedic
Program Application

STUDENT INFORMATION

Full Name: _____ Date: _____

Physical Address: _____

_____

Mailing Address: _____

Home Phone: _____ Email Address: _____

Mobile: _____

Current Employer: _____Phone:_____

Alternative Contact: Name_____Relationship:_____

Alternative Contact Phone: _____

Date of Birth: _____ Age: _____ Category: 16-17____18-25____26-44____45-99____

Race: ____ Social Security Number: _____

Course Information

Course Title: Paramedic Course No.: PM2017

Start Date: January 17, 2017 12 month program

Total Costs: $6470.00

T-Shirt Size:
Circle Male/Female
Circle Size: S – M – L – XL – XXL - XXXL

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REQUEST, AUTHORIZATION, CONSENT AND RELEASE FOR BACKGROUND INFORMATION

PLEASE TYPE OR PRINT

I, _____, understand that in conjunction with my application for admission to Nature Coast Emergency Medical Institute, that the Company will use the services of an outside agency to research and verify the information I have provided on my application including my personal background, character, professional standing, work history and qualifications. *Nature Coast EMI* uses a background screening company as an agent to perform these background verifications and this agency will provide a report to *Nature Coast EMI*.

I also understand that *Nature Coast EMI* and the background company will utilize various sources of information they deem appropriate, including but not limited to: Department of Motor Vehicle records, credit reporting agencies, criminal and civil court conviction records, current and former employers, government regulatory agencies, local, state or federal licensing boards or commissions, public or private associations, school records, military records, and professional and personal references.

I hereby grant *Nature Coast EMI* and its agents permission to access any and all applicable sources of information, including, but not limited to those listed above and unconditionally release and hold harmless *Nature Coast EMI*, *Professional Screening Services*, and any named or unnamed corporation, company, custodian of records or informant from any and all liability resulting from furnishing information about me.

_____ _____
Signed Date

_____ _____
Printed Name Position Applied For

_____ - _____ - _____ _____
Social Security Number Date of Birth

Other names you have used or are also known as:_____

PLEASE PROVIDE ALL RESIDENTIAL ADDRESSES FOR THE PAST 7 YEARS (Use back if necessary)

Current Residence:_____
Street Apt.# City State Zip # Yrs

Former Residence:_____
Street Apt.# City State Zip # Yrs

Former Residence:_____
Street Apt.# City State Zip # Yrs

Former Residence:_____
Street Apt.# City State Zip # Yrs

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Student Enrollment Agreement

ALL SIGNERS MUST RECEIVE AND READ A COPY OF THE BINDING DOCUMENT AND CATALOG.

STUDENT INFORMATION

Name: _____

Address: _____
STREET ADDRESS **CITY/STATE** **ZIP/POSTAL CODE**

Name of Parent/Guardian (if student is under 18): _____

Telephone: (Home) _____ (Business or Cellular): _____

Social Security Number: _____ Date of Birth: _____ Circle One: Male Female

_____

PROGRAM INFORMATION
(INSTITUTION ONLY)

Program Title: ____Paramedic_____Clock Hours: _1214___ Credit Hours:____0__

Class Schedule: ( ) full time ( ) part time (X) Day Classes ( ) Evening Classes

Hours per Week: _____ Start Date: ___/___/___ Anticipated Ending Date: ___/___/___

Days per Week: _____ Class Hours:_____ Total Class class: 12 months

Tuition	5020.00
Registration Fees	150.00
Books & Supplies	1145.00
Lab Fees	155.00
Total Program Cost	6470.00

Total Program Cost **$ 6,470.00**
Goods or Services not Included in the tuition $ _____

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METHODS OF PAYMENT

[ ] Full payment at time of signing enrollment agreement.

[ ] Registration fee at the time of signing enrollment agreement with balance paid prior to program start date

[ ] Registration fee at time of signing enrollment agreement with balance paid prior to taking midterm exam. .

ANNUAL PERCENTAGE RATE	FINANCE CHARGE	AMOUNT FINANCED The dollar amount the credit provided to you or on your behalf.	TOTAL OF PAYMENT The amount you will have paid after you have made all payments as scheduled.	TOTAL SALES PRICE The total cost of your purchase on credit including your down payment of
%	$	$	$	$

YOUR PAYMENT SCHEDULE WILL BE:

NUMBER OF PAYMENTS	AMOUNT OF EACH PAYMENT	WHEN PAYMENTS ARE DUE
	$	Beginning on ____/____/____ and on the same day each (check one) _____ weekly or _____ bi-weekly thereafter

Any late fee payments and conditions thereof must be disclosed on the enrollment agreement and in the catalog) All prices for program are printed herein. Contracts are not sold to a third party at any time. There are no carrying charges, interest charges, or service charges connected or charged with any of these programs unless stated.

CANCELLATION AND REFUND POLICY

Should a student's enrollment be terminated or cancelled for any reason, all refunds will be made according to the following refund schedule:

1. Cancellation can be made in person.
2. All monies will be refunded if the school does not accept the applicant or if the student cancels within three (3) business days after signing the enrollment agreement and making initial payment.
3. Cancellation after the third (3rd) business day, but before the first class, will result in a refund of all monies paid, with the exception of the registration fee (not to exceed $150.00).
4. Cancellation after attendance has begun, but prior to 40% completion of the program, will result in a Pro rata refund computed on the number of hours completed to the total program hours.
5. Cancellation after completing 40% of the program will result in no refund.
6. Termination date: When calculating the refund due to a student, the last date of actual attendance by the student is used in the calculation unless earlier written notice was received.
7. Refunds will be made within 30 days of termination of the student's enrollment or receipt of a Cancellation Notice from the student.

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GROUNDS FOR TERMINATION

A student's enrollment can be terminated at the discretion of the institution for insufficient academic progress, non-payment of academic costs, or failure to comply with rules and policies established by the institution as outlined in the catalog and this agreement.

EMPLOYMENT ASSISTANCE

Although placement assistance may be offered, the institution does not guarantee employment.

ACKNOWLEDGEMENT

This document and the catalog constitute a binding contract between the institution and the student and no further modification or representation except as herein expressed by both parties will be recognized.

CREDENTIAL AWARDED

Upon satisfactory completion of the program the student will be awarded a Paramedic Diploma.

DO NOT SIGN THIS CONTRACT BEFORE YOU HAVE READ IT OR IF IT CONTAINS ANY BLANK SPACES. ALL SIGNERS HAVE RECEIVED AND READ A COPY OF THE BINDING DOCUMENT AND CATALOG.

_____	_____	_____	_____
Signature of Applicant	Date	Signature of Parent/Guardian (If under 18 years of age)	Date

_____	_____
Signature of School Official	Date

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Student Payment Record

Student Name	
Course	**Paramedic**
Day or Evening	

Date	Amount	Method	Allocation	Balance

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RECEIPT OF MATERIALS

Student: _____ Date: _____
Textbook:
Paramedic

_____

_____

_____

_____

_____

_____ _____
Student's Signature Date

_____ _____
Witness Signature Date

Uniform Shirt received:
Polo Shirt Size: ___XL XXL XL L M S **Date received: _____**
T-Shirt Size: ___XL XXL XL L M S **Date received: _____**

_____ _____
Student's Signature Date

_____ _____
Print Witness Name Date

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COURSE POLICY SIGNATURE FORM

This form verifies that I, the student, have received a copy of the Paramedic course policies and procedures and a current catalog and that I, the student, am responsible for reading all the material provided.

I, the student, am also responsible for understanding all that is required of me while attending this course at Nature Coast EMI. I, the student, attest, that should I have any questions, I will ask for clarification for anything I do not understand.

By signing below, I, the student, am stating that I fully understand that I am responsible for upholding all of the policies and procedures set forth during my enrollment time in this Paramedic program.

_____ _____

Print Student Name Date

_____

Student's Signature

_____ _____

Print Witness Name Date

_____

Witness Signature

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Physicians Clearance

To: Program Director
3876 W. Country Hill Drive
Lecanto, Florida 34461

_____ has been examined
(Name of Applicant)

by me, and found to be in good physical condition, free of communicable diseases and is physically able to participate in EMS programs.

Date of Examination: _____

Restrictions (Visual, audible, sensory, or motor function)
_____
_____
_____

Medications (if any):
_____
_____
_____

Results of tuberculosis test: Negative: _____ Positive: _____

Proof of MMR: _____ Proof of Varicella Vaccination_____

_____ _____
Print Physician's Name Signature of Physician

_____ Date: _____
Address

_____ Date: _____
Student's Signature

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HEPATITIS B VACCINATION DECLINATION

I _____, understand that due to my occupational exposure to blood or other potentially infectious diseases, I may be at risk of acquiring the Hepatitis B Virus (HBV). I have been informed of and understand the risk associated with refusing to be vaccinated with Hepatitis B vaccine. However, I **decline** the Hepatitis B vaccination at this time. I understand that by declining this vaccination, I continue to put myself at risk of acquiring the Hepatitis B Virus.

Additionally, I hereby release Nature Coast EMI, Nature Coast EMS and its designees from any and all liability associated with my refusal of this vaccination.

_____ _____
Print Student's Name Date

_____ _____
Student's Signature SSN

_____ _____
Print Clinical Coordinator Name Date

_____
Witness Clinical Coordinator Signature

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NATURE COAST EMI
HOLD HARMLESS AGREEMENT

I, _____, am presently enrolled as a student in one of the training programs at Nature Coast EMI. My course of instruction at this school requires and encourages me to train, study, and receive instruction at Nature Coast EMI. I, the undersigned, agree to indemnify, protect, and hold harmless Nature Coast EMI, and its officers, directors, employee's and assignees, from any and all liability judgments, claims, costs, damages, or injury arising out of or in connection with any and all acts of negligent conduct on the part of the undersigned, however caused, during any instructional or training activity. I agree that I will attest and provide defense, at my own expense, any and all actions, lawsuits, or proceedings which may be brought against Nature Coast EMI, Inc., in connection with the above and shall satisfy, pay and discharge any and all judgments that may be entered against the Hospital or EMS Agency in any such actions or proceedings. I understand that, generally, while I am engaged in the activities of and related to this course of instruction and training, I am not considered an employee Nature Coast EMI and therefore I am not eligible for Workers Compensation coverage pursuant to Florida Statute Chapter 440 (1989-90, or its successor amendments and statutes); however, if I am otherwise considered lawfully "on duty or on the job" by my employer, I understand I may be entitled to Workers Compensation coverage through my employer. I understand that I am responsible for any medical care received by me should such a need arise throughout my training here at Nature Coast EMI or any other facility to which I am performing my clinical rotations.

_____ _____
Print Student Name Date

_____
Student's Signature

_____ _____
Print Witness Name Date

_____
Witness Signature

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Nature Coast EMI
INFORMATION RELEASE FORM

I, _____, understand that Nature Coast EMI Paramedic program requires participation in clinical rotations at surrounding area agencies/facilities as a part of the program. I also understand that each participating agency/facility has individual requirements and policies regarding student clinical hours and safety.

Information required by the clinical sites can be utilized and accessed in the Nature Coast EMI Paramedic program Student File. This file includes copies: Social Security Number (SSN#), proof of current certifications (CPR), proof of immunizations (PPD, MMR, HEP-B, Tetanus), current Drug Screening, and Background check and other items listed below.

I understand if any certification, immunizations expires before or during the program, I will be unable to participate in any clinical or complete the program. I am aware that Nature Coast EMI and its faculty and affiliates are under no obligation to provide special consideration for clinical if I choose not to comply with the facility and/or program prerequisites. I also understand, it is the student's responsibility to keep current.

I agree to comply with the Paramedic program and agency/facility requirements. I hereby give Nature Coast EMI permission to release required information to Nature Coast EMI affiliating clinical agency/facility while I am a student in the Paramedic program.

Initial "EACH" item individually to acknowledge this request and give your permission to release required information to Nature Coast EMI's affiliate agencies/facilities.

CPR Card- Yes _____ **MMR** - Yes _____ **Tetanus** - Yes _____
PPD - Yes _____ **Physical Exam** - Yes _____**Varicella** - Yes _____
Drug Screening - Yes _____ **Background Check** - Yes _____

_____ _____
Print Student Name Date

_____
Student's Signature

_____ _____
Print Witness Name Date

_____
Witness Signature

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Nature Coast EMI PARAMEDIC PROGRAM
SUBSTANCE ABUSE / DRUG ABUSE STATEMENT

I, _____, do swear that I am not currently taking any illegal drugs or illegal substances. I understand that I must not take any illegal drugs during the course of my class, nor should I consume any alcohol prior to any class time or prior to any clinical rotations. I understand if I choose not to follow this guideline that I **WILL** be dismissed from the course.

_____ _____
Print Student Name Date

_____
Student's Signature

_____ _____
Print Witness Name Date

_____
Witness Signature

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DRUG TESTING ACKNOWLEDGEMENT FORM

I_____, understand that as part of the Nature Coast EMI Paramedic Program, all students are required to undergo a 10 panel drug screening prior to the start of the above referenced program. Nature Coast EMI requires a drug screening for all students to determine suitability to attend clinical rotations. I, the student, understand that a negative drug test result is what is required to continue on with this program. I, the student, understand that if I refuse to undergo the testing, I will not be cleared to do clinical rotations, therefore would not meet one of the programs requirements and furthermore risk being dismissed from the program. I, the student, understand that if I produce a positive test result for illegal drug use, I will not be cleared to do clinical rotations until a negative test result is produced. I, the student, further understand that I am allowed to retest, at my own expense within fifteen (15) days of the prior test.

By signing below, I swear and attest, I have read and understand the information contained on this "Acknowledgement Form".

_____ _____
Print Student Name Date

_____
Student's Signature

_____ _____
Print Witness Name Date

_____
Witness Signature

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HIPAA
A GUIDE FOR
NATURE COAST EMI PARAMEDIC STUDENTS

HIPAA: HIPAA is the Health Information Portability and Accountability Act. The HIPAA Privacy Rule goes into effect on April 14, 2003 and imposes civil and criminal penalty for unauthorized disclosure of a person's Protected Health Information (PHI).

PHI: PHI is Protected Health Information. Any health information that can identify a patient to their personal health information is considered PHI. PHI includes the patient's name, social security number, in-hospital ID number, address and all medical related information. In short, any information that could help someone discover PHI in relation to a specific person. All forms of PHI written, spoken or electronic are protected by HIPAA.

Categories of Healthcare Workers that the HIPAA Legislation Applies to:

Every worker in the healthcare environment (housekeepers, nurses, pharmacists, financial personnel, lab staff, food service workers, on-site contractors, volunteers, students, etc.) is affected by this legislation and must comply with Hi PAA and know how it applies to them in their job.

Healthcare Providers Use of PHI:

Healthcare providers may use PHI for

- Treatment of the patient - exchange information with other healthcare providers caring for the patient. However, healthcare workers must make an effort to disclose only the minimum necessary information needed to do their job.
- Payment - exchange the information necessary to pay the patient's expenses.
- Healthcare Operations - exchange of PHI can occur as necessary for the operation of the hospital (billing and other necessary operations).

Authorizations:

In order to use a patient's Protected Health Information (PHI) for anything other than treatment, payment or healthcare operations, an authorization must be obtained from the patient. An authorization must be very specific and must disclose to the patient, the specific PHI that will be disclosed, who it will be released to and for what reason. Students should have the nurse in charge of the patient obtain all authorizations.

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Special Circumstances:

There are some special circumstances when PHI can be released without an authorization. Examples include:

- To comply with State Health Agency regulations for reporting diseases
- Reporting abuse according to law
- Reporting to the FDA about medical devices malfunctions or breakage
- Information to police about patients when conducting a criminal investigation

Opt Out:

"Opt Out" applies to disclosures of PHI to the patient's family and friends involved in their healthcare and to use information in the facility directory. The patient has the opportunity to refuse or "opt out" of this type of disclosure.

For patients who have 'Opted Out' (meaning they have decided they do not want ANY information about them to be released) we cannot even acknowledge that they are in the hospital to anyone other than those who are responsible for their treatment/payment/hospital operations.

How does "Opt Out" affect students caring for the patient? Students caring for the patient should not discuss any patient information or acknowledge that the patient is in the hospital unless it is with other healthcare professionals assigned to the patient's case. All other inquires should be referred to Nature Coast Emergency Medical Institute Representative such as the nurse in charge of the patient.

Proper handling/disposal of written PHI.

Patient chart information is a permanent record and handled according to current hospital policy. Non-chart documents containing PHI should be placed in the "Shred It" box when no longer being used. Example: there is a patient problem you are following up on and in order to handle that problem you have had to write down the patient's name, ID number and room number. When that document is no longer being used, it should be placed in the 'Shred It' box.

How to handle transmission of PHI via fax or phone or email?

Students participating in patient care at CSRHC should request the assistance of the patient's nurse or another CSRHC Associate and allow them to handle all phone inquires or email or fax transmission of PHI.

How to respond to the accidental disclosure of PHI by you or someone else?

If you discover you have accidentally (or someone else on staff) disclosed PHI... immediately:

- Report it to the Nature Coast Emergency Medical Institute Representative.
- Report the occurrence to the unit's manager/supervisor

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The Privacy Officer/Manager will need to make sure that the:

- Person who received the PHI in error is informed that they have received confidential information in error and cannot release that information to anyone else
- Patient is informed that their PHI has been released in error, who received that information and what information was disclosed.
- Accidental disclosure is documented appropriately in the patient's medical record.

For Questions or Concerns about HIPAA contact the Nature Coast Emergency Medical Institute campus for further information and guidance.

I have read and understand the HIPAA policy and will abide by them:

_____ _____
Print Student Name Date

_____
Student's Signature

_____ _____
Print Witness Name Date

_____
Witness Signature

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INFECTIOUS DISEASE CONSENT FORM

I, _____ , understand that as a clinical student, I may be exposed to environmental hazards and infectious diseases including, but not limited to, Tuberculosis, Hepatitis B, and HIV while in the clinical/field internship rotations. I will obtain or proof I am current on all s required immunizations.

Neither, Nature Coast Emergency Medical Institute nor any of the clinical sites used for clinical rotations assumes any liability if a student is injured on the campus or at a clinical site during the program unless the injury is a direct result of negligence by the school or clinical facility involved. I understand that I am responsible for the cost of health care for any personal injury I may suffer during my education. I also understand I may purchase accident insurance through a private company, if I so desire.

I further understand and assume responsibility for the policies, objectives, course requirements and inherent risks involved in medical education and the pre-hospital medical programs at Nature Coast EMI.

_____ _____

Print Student Name Date

_____

Student's Signature

_____ _____

Print Witness Name Date

_____

Witness Signature