



**Oak Hill Hospital**

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## OAK HILL HOSPITAL/ NATURE COAST EMERGENCY MEDICAL INSTITUTE CONSORTIUM FOR PARAMEDIC EDUCATION

3876 W. Country Hill Dr., Lecanto, FL 34461

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     |
| 18. Technical Standards   | ___ Signed and Returned |



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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](mailto: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 11 2018 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	<u>5020.00</u>
Registration Fees	<u>150.00</u>
Books & Supplies	<u>1145.00</u>
Lab Fees	<u>155.00</u>
<b>Total Program Cost</b>	<b><u>6470.00</u></b>

**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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INSTITUTE CONSORTIUM FOR PARAMEDIC EDUCATION**

*3876 W. Country Hill Dr., Lecanto, FL 34461*

**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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# OAK HILL HOSPITAL/ NATURE COAST EMERGENCY MEDICAL INSTITUTE CONSORTIUM FOR PARAMEDIC EDUCATION

3876 W. Country Hill Dr., Lecanto, FL 34461

## 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

\_\_\_\_\_  
Address

Date: \_\_\_\_\_

\_\_\_\_\_  
Student's Signature

Date: \_\_\_\_\_



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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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*3876 W. Country Hill Dr., Lecanto, FL 34461*

### **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



**Oak Hill Hospital**

TOGETHER, PERFORMING AT A HIGHER STANDARD®



## **OAK HILL HOSPITAL/ NATURE COAST EMERGENCY MEDICAL INSTITUTE CONSORTIUM FOR PARAMEDIC EDUCATION**

**3876 W. Country Hill Dr., Lecanto, FL 34461**

Paramedic students enrolled in the Oak Hill Hospital/Nature Coast Emergency Medical Institute must meet the following requirements to perform effectively in the educational activities of the program and in the paramedic profession.

1. Meet all requirements for the certification of Paramedic in compliance with State of Florida guidelines.
2. Be responsible for the patient care entrusted to the extent defined and authorized by the EMS Medical Director and/or on-line physician control, and Florida Law, and continues patient care until relieved by an equally or more highly qualified individual.
3. Administers Advanced Life Support (ALS) techniques as defined and authorized by the EMS Medical Director and/or on-line physician control and in accordance with Florida Law. May act as the Incident Commander or Medical Sector on a medical emergency scene.
4. Responds to medical calls and makes decisions as to the best possible methods of patient assessment and treatment.
5. Uses proficient appropriate terminology and professionalism while maintaining appropriate communications with physicians and/or other medically oriented individuals.
6. Uses proficient appropriate terminology and professionalism while maintaining appropriate communications with EMS Dispatch and allied agencies.
7. Must be able to complete activities that require moderate physical exertion and/or physical strain to the point of physical fatigue. Must be able to bend and lift a minimum of 150 pounds. Work environment involves exposure to job hazards where there is a possibility of injury and/or exposure to blood borne pathogens.
8. Independent judgment is required to identify, select, and apply the most appropriate of available guidelines and procedures, interpret precedents, and adopt standard methods or practices to meet variations in facts and/or conditions.
9. Required to have and maintain (1) Current State of Florida EMT certification, (2) Current Healthcare Provider CPR certification.
10. Paramedic activities consist of moderately complex procedures and tasks where basic analytic ability is required. Activities may involve the comparison of numbers, selection of appropriate guidelines procedures, medical protocols, operate complex advanced life support equipments, and perform medication calculations all under high stress situations.
11. Independent judgment is required to identify, select, and apply the most appropriate of available guidelines and procedures, appropriately apply medical protocols and procedures. Function in environment of loud noises and flashing lights.
12. Requires regular contact within the EMS agency with other EMS professionals, and with other departments, outside agencies or the general public, supplying or seeking information.
13. The paramedic student is expected to protect the privacy of all patient information in accordance the School's and EMS Company's privacy policies, procedures, and practices, as required by State and Federal Law.
14. Requires appropriate documentation of patient care and information vital to the patient medical record.
15. Requires appropriate and empathetic customer service skills in all situations.

### **DECLARATION**

On this date, I have received a copy of the paramedic technical standards relating to my paramedic education with Nature Coast Emergency Medical Institute.

Printed Name \_\_\_\_\_ Signature: \_\_\_\_\_ Date \_\_\_\_\_