PHOENIX COLLEGE

A MARICOPA COMMUNITY COLLEGE

2020

EMERGENCY RESPONSE PROGRAMS

EMERGENCY MEDICAL TECHNICIAN (EMT) EDUCATION PROGRAM

Name: _____
Last First Middle

Current Address: _____
Street City State Zip Code

Contact Numbers: (_____) _____ (_____) _____ (_____) _____
Home Work Cell Phone or Pager

Email Address: _____ **Date of Birth:** _____

The Emergency Medical Technician certification is the gateway process for a career pathway in Emergency Medical Services. Phoenix College is currently advising and enrolling interested and dedicated students for the program. Day and evening sessions are currently available however, course sessions are limited to first come first served in the enrollment process.

PRIMARY FOCUS OF THE EMT:

The EMT provides basic emergency medical care and transportation for the sick and injured, both critical and emergent patient(s) who access the EMS 911 system. The EMT possesses the basic knowledge and skills necessary to provide patient care and transportation. The EMT functions as part of a comprehensive EMS response, under medical oversight from the scene to the emergency health care system.

PRIMARY EDUCATIONAL MISSION AT PHOENIX COLLEGE:

To prepare competent professional EMT's for state and national certification, to obtain employment in the emergency services and other areas of the health care delivery system. This is accomplished through providing competent dedicated education and training to the student to prepare them to obtain the National Registry of Emergency Medical Technician certification and become an Arizona certified Emergency Medical Technician.

Please contact the Phoenix College Advisement department for an appointment and information at 602-285-7777 or visit them on the web at www.phoenixcollege.edu/students/advisement. Please review the student handbook and catalog for additional information on registration; these materials can be located at www.phoenixcollege.edu.

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ENROLLMENT REQUIREMENTS:

___ **Student must be at least 18 years of age at the time of enrollment.**

___ **Student must have ONE of the following:**

1. **ACCUPLACER Next Generation score of 249 or higher**
   OR
2. **Associate's degree or higher from and accredited college or university**

REQUIRED COURSES:

___ **EMT 101 (Designed to provide the allied healthcare provider with the knowledge and skills to perform Basic Life Support (BLS) according to current guidelines for emergency cardiovascular care (ECC).**

___ **EMT 104 (Designed as the Emergency Medical Technician (EMT) lecture to prepare students for scope of practice and standard of care with comprehensive assessment, diagnostic technology, patient advocacy, ethical and professional behaviors, critical thinking, decision-making, and patient management of medical and trauma emergencies and non-emergencies).**

___ **EMT 104LL (Designed as the simulated Emergency Medical Technician (EMT) practicum in which the student synthesizes standard of care and scope of practice with comprehensive assessment and diagnostic technology, patient advocacy, ethical and professional behaviors, critical thinking, decision-making, and patient management of medical and trauma emergencies. Provides scenario based learning applied to the techniques of emergency medical care in accordance with national and state curriculum).**

___ **EMT 104AB (Applied Practical Studies for EMT. Simulated patient encounter course, with practical application of techniques and skills covered in the EMT curricula. Student are to actively participate in team leader and team member roles as assigned by the evaluator during the course. Complete 10 simulated patient encounter forms, achieve a passing assessment score of 75% or better on all EMT skills. Utilize appropriate order model communications during the course).**

REQUIRED DOCUMENTS TO BE TURNED IN ON THE FIRST DAY OF CLASS (if you have completed the required documents prior to the first day of class, bring documents to the EMT Department in the PSB Building):

___ **Copies of reading ACCUPLACER Next Generation score of 249 or higher OR Associates degree or higher**

___ **Current Immunization Records / Current Physical Examination**

1. ___ **Mumps, Rubella and Rubeola (proof of immunity by positive antibody titer or 2 doses of MMR vaccine)**
2. ___ **Varicella (proof of immunity by positive IgG titer, by positive history of chickenpox or 2 doses of Varicella vaccine)**
3. ___ **Tdap (proof of tetanus/diphtheria vaccine within the last 10 years)**
4. ___ **Influenza (proof of influenza vaccine for current annual year enrolled or declination form)**
5. ___ **Hepatitis B (proof of immunity by positive HbsAb titer, 3 doses of HEP B or declination form)**
6. ___ **Tuberculosis (negative blood test either QuantiFERON or TSPOT, negative chest x-ray or 2-step TB Skin Test. Results must be within the last 6 months of the first day of class)**
7. ___ **Physical Examination by a MD, DO, PA or NP with signature**

COURSE MATERIALS TO BE PURCHASED AT THE PHOENIX COLLEGE BOOKSTORE

___ **Navigate 2 Premier Access for Emergency Care and Transportation of the Sick and Inured 11th edition ISBN: 97811284110531 Author: AAOS Estimated Price: $348.95 (ebook)**
https://www.psglearning.com/catalog/productdetails/9781284110531 **REQUIRED**

Note: Failure to provide the documentation as explained in the advisement packet (process) and outlined on this checklist shall result in you being dropped from the program with a 100% refund, on the first day of class. Please make copies of all of your document in advance in preparation for the first day. All copies will become part of our student records in compliance with HIPPA Act, ARS Title 13, Arizona Administrative Code Title 9 Chapter 25.

*** * * FOR PHYSICIAN USE ONLY * * ***

PATIENT NAME	AGE	HEIGHT	WEIGHT
_____	_____	_____	_____

PHYSICAL EXAMINATION

DATE: _____

HEENT: _____ **Lungs:** _____

Heart: _____ ****Pulse:** _____ ****BP:** _____

Abdomen: _____ **Extremities/Joints:** _____

Neurologic/Mental: _____

****Vision: R** _____ **L** _____ ****Corrected: R** _____ **L** _____

(indicates the numerical assessment must be documented)**

Paramedic candidate must possess the following ability:

1. Strength
Physical strength to lift and carry heavy loads.

2. Mobility
Able to bend, squat, and crawl on even and uneven terrain

3. Manual Dexterity
Ability to move the hand and fingers in coordinated and exact movements

4. Vision
Perfect vision is not a requirement, but must sufficient to perform the required tasks of a student

Based on this physical, do you find any reason why this person cannot physically perform these activities?

Yes _____ **No** _____

If yes, please explain: _____

_____

PHYSICIAN'S INFORMATION

Name: _____ **MD, DO, PA, FNP** **Signature:** _____
(Please Print) (Circle One)

Address: _____ **City:** _____ **State:** _____ **Zip Code:**_____

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Student Name: _____ **Date:** _____

Immunizations

1. **Negative 2-Step Tuberculin Intermediate Skin Test (PPD): (Must be good thru the duration of the course)**
   - **Date #1** _____ **Result #1** _____ **Date #2** _____ **Result #2** _____

   OR

   Chest X-Ray
   - **Date** _____ **Result** _____

   OR

   Negative Blood test (QuantiFERON or TSPOT)
   - **Date** _____ **Result** _____
2. **MMR Vaccine**
   - **Date #1** _____ **Date #2** _____

   OR

   MMR Titer (must have a positive antibody titer)
   - **Date** _____ **Rubeola Result** _____
   - **Date** _____ **Mumps Result** _____
   - **Date** _____ **Rubella Result** _____
3. **Varicella Vaccine**
   - **Date #1** _____ **Date #2** _____

   OR

   Varicella Titer (proof of immunity by positive IgG titer)
   - **Date** _____ **Varicella Titer Result** _____

   OR
   - **Doctor's NOTE dating when you had exposure to Chicken Pox**
4. **Tdap (within the last 10 years)**
   - **Date** _____
5. **Influenza (Must be good thru the duration of the course)**
   - **Date** _____
6. **Hepatitis B Vaccine Series (if you are not receiving the Hepatitis B Vaccine please sign the declination)**
   - **Date #1** _____ **Date #2** _____ **Date #3** _____

   OR

   Hepatitis B Titer (proof of immunity by positive HbsAb titer)
   - **Date** _____ **Hepatitis B Titer Result** _____

Physician Name: _____ **Physician Signature:** _____

Hepatitis B Declination

If you choose to decline the Hepatitis B series, please read and sign the following section:

I understand that due to my exposure to blood or other potentially infectious materials during the clinical portion of my health science program, I may be at risk of acquiring Hepatitis B virus infection. I have been encouraged by the EMT Department faculty/staff to be vaccinated with Hepatitis B vaccine, however, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. By signing this form, I agree to assume the risk of a potential exposure to Hepatitis B virus and hold Maricopa Community College District as well as all hospital and pre-hospital clinical observation sites harmless from liability in the event I contract the Hepatitis B virus.

Student Name (print)	**Student Signature**
Date	**Student ID #**

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2019-2020 Seasonal Influenza Declination

I understand that due to the nature of health care and the volume of individuals that I may come in contact with, I may be at risk of acquiring an influenza virus. The health requirements for the allied health program in which I am enrolled, as described in the Student Handbook, include the current influenza vaccination as identified by the Centers for Disease Control for the current influenza season as part of the program's requirements. I have been encouraged by the faculty to be vaccinated; however, I decline the influenza vaccination at this time, I understand that by declining this vaccine, I continue to be at risk of acquiring influenza. By signing this form, I agree to assume the risk of potential exposure to influenza and hold the Maricopa Community College Allied Health Program as well as all health care facilities I attend as part of my clinical experiences harmless from liability in the event I contract the virus. I also understand that, due to the contagious nature of the virus, that a health care setting may not accept my placement if I refuse vaccination.

Student Name (print)	**Student Signature**
Date	**Student ID #**

This form cannot be used in CastleBranch Medical Document Manager.

DO NOT upload this document into CastleBranch or myClinicalExchange. If your program is using CastleBranch (CB) Medical Document Manager, you will need to obtain their Influenza Vaccination Declination Form from CastleBranch will require proof of Declination of Flu Immunization due to Religious Beliefs; or Declination due to Medical Contraindication: (Medical Provider to Indicate reason for contraindication).

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Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

HAVE YOU HAD OR DO YOU HAVE:	YES	NO
Vision or Hearing Problems (if yes, please explain)		
Heart Problems (if yes, please explain)		
Childhood diseases (if yes, please explain)		
Epilepsy, Diabetes, High Blood Pressure, Kidney Problems (if yes, please explain)		
Bone/joint disease or injury, back injury (if yes, please explain)		
Serious Injuries/Major surgery, Hernias (if yes, please explain)		
Mental Illness/Nervous Disorder (if yes, please explain)		
Drug/Alcohol problems (if yes, please explain)		
Lung disease (if yes, please explain)		
Skin problems/diseases (if yes, please explain)		

I hereby certify that this information is true to the best of my knowledge.

Student Name (print)	Student Signature	Date