Please indicate in which Paramedic program offering you are applying:

____ Day Program     ____ Evening Program

PARAMEDIC PRE-ADMISSION PREREQUISITES

1. Be at least 18 years of age at the start of the program.

2. Be an Emergency Medical Technician, preferably with at least one year's experience.

Submit an Admissions Application and a copy of their medical insurance, driver's license, high school diploma or GED Certificate and any college transcripts, proof of current EMT, CPR, ICS-100 completion, FEMA IS-700 completion, HAZMAT R&I completion.

3. Complete a personal health history form and submit a physical examination form completed and signed by a family physician which immunizations listed on the health history form (below).

4. Complete and submit results from an FBI-fingerprint background check without disqualifying results.

5. Complete and submit results from a Pennsylvania Child Abuse History Clearance check without disqualifying results.

6. Complete and submit results from a Pennsylvania State Background check without disqualifying results.

7. Have filled out the necessary Financial Aid Applications.

8. Have submitted payment for textbooks or have made payment arrangements with the Business Office.

9. Have paid all admission fees.

10. Complete the college assessment test and written entrance exam (EMT-basic level).

11. Successfully complete an oral interview conducted by the Director of Paramedic Training Program or designated program staff.

12. Have acquired the Paramedic program Uniform.

13. Submit to Urine Drug Screening

All students are required to pay materials/registration fees prior to the start of class. Any student not paying these fees in full will not be admitted into class. No exceptions will be made.
APPLICATION FOR ADMISSION
PERSONAL INFORMATION

NAME: _______________________________________
Address_______________________________________DOB___________________
________________________________________AGE___________________
PHONE NUMBER______________________________ _______________________
                                             Home                                                  Work

DATES
Date of Interview ______________________ By____________________________________
Date of Acceptance ______________________ By____________________________________

GENERAL INFORMATION

EMT CERTIFICATE EXP DATE________________________ STATE ______________
ALS AFFILIATE_________________________________________________________

ACADEMIC

Pre-Admission Test Date______________________________
Interview Date_____________________________________

Paramedic Training Institute
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HEALTH INFORMATION FORM

EVERY APPLICANT FOR ADMISSION MUST COMPLETE THIS FORM:

Name ____________________________________________ Sex ________

Address________________________________________________________________________________________

Phone________________________________ Date of Birth __________

PERSONAL HISTORY
1. Have you lived in close contact with anyone who had Tuberculosis?
   No__________ Yes ___________ Explain ______________________________________________________________

2. Have you ever had any of the following? None check here___________________________
   ___Rheumatic Fever/               ___ Diphtheria
   ___Allergies (specify) ____________
   ___Cholera                        ___ Poliomyelitis
   ___Heart Disease                  ___ Gland Trouble     ___Hernia
   ___ Hay Fever/Asthma              ___ Tuberculosis     ___Diabetes
   ___ Food Sensitivity              ___ Speech Disorder  ___ Epilepsy
   ___ Recurrent Headaches          ___ Kidney Disease   ___ Scarlet Fever
   ___ Convulsions/Blackouts         ___ Nervous Tendencies ___ Bone/Joint Trouble

   If checked, please explain: ________________________________

LAST DATES OF IMMUNIZATIONS
___ Smallpox               ___ Tetanus Toxoid           ___Polio       ___ Tuberculosis

3. Among your blood relatives, is there any history of /or present illnesses from the following?
   ___Cancer                  ___Diabetes                  ___ Tuberculosis
   ___Stroke                  ___Allergies                  ___Convolusions
   ___Nervous                 ___Heart Disease            ___ High Blood Pressure

   If checked, what condition, which relative? ________________________________

4. Dates of significant injuries or operations which you have had:
   If none, check here: ______
   Injury or operation? ____________________________
   Date________
   Explain________________________________________

5. Based on your most recent physical examination, do you have any physical limitations
   which would effect your participation in the classroom or activities such as physical
   education?
   If no, check here ______ Yes, Explain______________________________________________________________

6. Date of last chest x-ray? ________________________Findings ______________________

7. Do you presently feel the need for Psychological or Health Counseling?
   If not, check here ______
   Check services desired: Health Counseling _____ Psychological Counseling______
EMERGENCY CONTACT INFORMATION

1. In case of emergency, person to be contacted:

   Name___________________________________________________________
   Address__________________________________________________________
   Phone____________________ Relationship ______________________

2. In time of an emergency, I hereby authorize and direct the college to send me to the hospital or physician most readily accessible, and/or to administer necessary emergency care.

   Student’s Signature________________________________ Date ____________

3. Type of Insurance/Plan Number___________________________________________

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PHYSICAL EXAMINATION AND IMMUNIZATION FORM

Student Name______________________________

REQUIRED MEDICAL IMMUNIZATIONS (to be completed by Physician)

*All dates are required*

- Tetanus (booster every 10 years)  
  Date of last immunization_________________

- Polio  
  Date of last immunization_________________

- Measles-Mumps-Rubella (MMR)  
  Date of last immunization_________________  
  Date of last immunization_________________

- *Hepatitis B Vaccine  
  Date of last immunization_________________

Testing

Two Step- TB
- First shot: Date Given: _____  Date Read: _____  Result: _______
- Second Shot: Date Given: _____  Date Read: _____  Result: _______

RECOMMENDED MEDICAL IMMUNIZATIONS

- Influenza  
  Date of last immunization_________________

- Typhoid  
  Date of last immunization_________________

If the physician feels certain immunizations are not necessary, please include a statement to that effect. In the space below, a statement from the physician certifying the following:

- the student was seen for a physical exam & date the student was seen
- the student is/is not physically fit
- student is/is not free of lifting restrictions
- the student is/is not free of communicable diseases

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Physicians Signature ___________________  Physicians Name Printed ___________________  Date _______

*Note: If student declines to be immunized against Hepatitis B, a declination statement must be provided.

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HEPATITIS B DECLINATION STATEMENT

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) injection. I have been given the opportunity to vaccinate with Hepatitis B vaccine and decline at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B Vaccine I will do so at my own cost.

______________________________________________
Student Signature                                         Date

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FINANCIAL INFORMATION

In addition to previous program prerequisites, students must fill out appropriate financial aid applications. An appointment can be made by calling the Lackawanna College Financial Aid Office at 961-7859.

Registration Fee $115.00
(Fee is non-refundable and must be submitted with the application. Testing will not be scheduled until fee is paid.)

Credentialing Fees $710.00
(Fee is non-refundable and due upon acceptance into the program.)

Books and Clinical Software $980.00
(Fee is non-refundable and due upon acceptance into the program.)

All fees, including registration, uniform and books must be paid in full before the semester begins.

Tuition:

First Semester $6,000.00
Second Semester $6,000.00

Total cost for the program $13,805.00

*Students who qualify may receive funding through Financial Aid to cover the full cost of tuition.
Financial Aid Information

Lackawanna College makes every effort to help students meet their educational expenses. All students are encouraged to complete a Free Application for Federal Student Aid (FAFSA), which are available in the Financial Aid Office. The Federal Pell Grant and several loan programs may be available to eligible paramedic students. Please call 570-961-7859 to schedule an appointment.

Business Office Information

The College requires that all tuition be paid in full prior to classes beginning in any semester. Any and all collection expenses incurred by the College to collect any delinquent receivables are the responsibility of the student.

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