 **EMT - B**  **PARAMEDIC**  **ASSOCIATE OF SCIENCE DEGREE**  **FIRE PROGRAMS**

**Semester: \_\_\_ Summer \_\_\_ Fall \_\_\_ Spring 20 \_\_\_\_**

**PLEASE PRINT:**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STUDENT ID NO.:

(LAST) (FIRST) (MIDDLE)

MAILING ADDRESS:

(STREET OR BOX) (CITY) (STATE) (ZIP)

PHYSICAL ADDRESS:

(IF DIFFERENT) (STREET OR BOX) (CITY) (STATE) (ZIP)

HOME TELEPHONE NUMBER: WORK TELEPHONE NUMBER:

E - MAIL: PAGER OR CELL PHONE NUMBER:

Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Date of High School Graduation: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

**IN CASE OF EMERGENCY PLEASE NOTIFY:**

PRIMARY:

(RELATIONSHIP) (NAME) (PHYSICAL ADDRESS, CITY, STATE) (TELEPHONE NUMBER)

SECONDARY:

(RELATIONSHIP) (NAME) (PHYSICAL ADDRESS, CITY, STATE) (TELEPHONE NUMBER)

**EMERGENCY MEDICAL INFORMATION**

|  |
| --- |
| SIGNIFICANT MEDICAL HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MEDICATIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  BLOOD TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_ PHYSICIAN(S): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Health Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Attach copy of Health Insurance card – copy both sides please)**

**Resume**: Please attach a resume that reflects your experience in healthcare. Include a cover letter that identifies why you are choosing the EMS/Fire programs, your plan for success in the courses and your anticipated goals in healthcare/public safety.

**Application**: I certify that all information provided is true and complete. I understand that any misrepresentation or omission may result in my disqualification from consideration for admission into the emergency medical services program and/or my termination from the program. I hereby release, indemnify, and hold harmless Florida Gateway College from any and all liability based on their authorized receipt, disclosure, and use of the information gathered in processing my application. I understand that, if accepted, completion is contingent upon a satisfactory criminal background check, passing a drug screen, and my ability to perform all essential skills and functions.

**Disability Statement:** FGC will adhere to all applicable federal, state, and local laws, regulations, and guidelines with respect to providing reasonable accommodations as required affording equal educational opportunity. Students may obtain further assistance and information by calling Janice Irwin, coordinator of disability services, at (386) 754-4215. The Disability Services Office is located in Building 017, Room 21, at 149 SE College Place, Lake City, Florida 32025.

**EA/EO Statement:** Florida Gateway College does not discriminate in education or employment related decisions on the basis of race, color, religion, national origin, gender, age, disability, marital status, genetic information, or any other legally protected status in accordance with the law. The Equity Officer is Sharon Best, Director of Human Resources, 149 SE College Place, Lake City, FL 32025, who may be reached at (386) 754-4313.

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

For greater student efficacy or regarding issues of personal/family concern for EMS students while on campus in classrooms and during clinical rotations,

PLEASE LIST INDIVIDUALS APPROVED TO KNOW OF STUDENT’S LOCATION:

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

PLEASE LIST INDIVIDUALS WHO SHOULD NOT HAVE INFORMATION OR KNOWLEDGE OF STUDENT’S LOCATION OR ANY OTHER INFORMATION:

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**