Community Health Network

Emergency Medical Technician Course Application

January 2018

First day of Class January 8, 2018
EMERGENCY MEDICAL SERVICES & EDUCATION

Thank you for your consideration in choosing Community Health Network EMS Training programs. We are currently in the process of compiling a roster for our next Emergency Medical Technician program.

The next Emergency Medical Technician course has been scheduled to begin on **January 8, 2018**. Classes will be held on Monday and Wednesday evenings from 6pm – 9:30pm or Thursday’s 8:30 to 4:40, at Community Hospital East.

There are some requirements of eligibility that you must meet in order to be enrolled into the program and ultimately certified by the State of Indiana as an Emergency Medical Technician.

1. You must be at least 18 years of age by the end of the program.
2. You must have a high school diploma or GED equivalent by the end of the program.
3. You must hold a current AHA Healthcare Provider CPR card. You must have the card on the first day of class. Or plan to attend the CPR Class on **January 3, 2018** at 6:00pm, with an additional cost of $50.00.
4. You must not have been convicted of any felony crimes.
5. You must obtain the immunizations as listed on the application prior to doing clinical time.

- Cost of the class will be $850.00. Cash, credit card or money orders only.
- Textbooks and workbooks will be distributed the first night of class.
- $250.00 is required to secure your position in the program. *This deposit includes a $100 non-refundable application fee.*
- The balance of the tuition ($600.00) will need to be paid by **January 8, 2018** unless other arrangements have been made prior to the start of class.
- All classes will be held at
  - Community Hospital East
  - 1500 N. Ritter Ave.
  - Indianapolis, IN 46219

Class will be limited to students with tuition payment and that meet all admission qualifications. We look forward to working with you to achieve your goal of becoming an EMT.

If you have any questions, please feel free to contact Terri at (317) 355-2433.

Cordially,

Terri R. Hamilton, NREMT-P, PI
EMS Educator

08/23/17
# APPLICANT INFORMATION

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<tr>
<th>Name:</th>
<th>Driver License #</th>
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<td>Date of Birth: / /</td>
<td>Age:</td>
<td>SSN: (optional)</td>
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<tr>
<th>Home Address:</th>
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<th>City, State, Zip:</th>
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<tr>
<th>County of Residence:</th>
<th>Phone: ( )</th>
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<tr>
<th>Current Employer</th>
<th>EMS Affiliation(if any)</th>
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<th>Email Address:</th>
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**IN CASE OF EMERGENCY, CONTACT:**

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<th>Mr.</th>
<th>Mrs.</th>
<th>Ms.</th>
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<th>Relationship:</th>
<th>Phone Number: ( )</th>
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# EMERGENCY MEDICAL SERVICES INFORMATION

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<th>Healthcare Provider CPR Certification Expiration Date: / /</th>
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*Certification is required for entrance into the program*

_____ I will need to attend the CPR Class on January 3, 2018, at 6:00 pm  
Please send additional payment of $50.00.
EDUCATIONAL INFORMATION

High School (Name, City, State):

Graduation Date: ___________ Attach copy of Diploma ________

Business / Technical School:

Dates Attended: Degree:

College:

Dates Attended: Degree, Major:

Have you ever been charged or convicted of any crimes other than minor traffic violations? YES NO

Explain in full: _________________________________________________________

** Conviction of a felony may have a bearing on your ability to be certified in the State of Indiana **

Do you have any disabilities that could directly affect your performance as a student? YES NO

(lifting, bending, hearing, etc.)

If yes, please explain _____________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Have you ever been employed by Community Health Network in the past or present? YES NO

If yes: Dates employed: From: ___________ To: ___________

If applicable: Reason for leaving: __________________________________________

_____________________________________________________________________

I certify that my answers are true and complete. I understand that I will be subject to immediate termination from the EMT Program for any information that has been falsified.

Signature of Applicant: ___________________________ Date: ___________

Please submit this application with copies of high school diploma or GED, Driver License and Healthcare Provider CPR Certification to:

Terri R. Hamilton, AS, NREMT-P, PI
Community Health Network
EMS Education
1500 North Ritter Avenue
Indianapolis, IN 46219
Thamilton2@ecommunity.com 317-355-2433 Fax 317-351-2419

08/23/17
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<th>Applicants Name:</th>
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**APPLICATION PACKET:**

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<th>Application #:</th>
<th>Date Rec'd.:</th>
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**Immunizations:**

Provide Proof of the Following:

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<th>MMR</th>
<th>Hepatitis B</th>
<th>TB</th>
<th>Tetanus</th>
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*Immunizations must be complete before going to clinical sights.*

**Application Complete**

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<th>Yes</th>
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**ACCEPTED**

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**Via:**

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08/23/17
Consent and Release to Conduct Criminal Background Check(s)

I, ______________________________________________, hereby authorize Community Health Network and/or its agents to conduct an investigation of my background, criminal or police records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained on my application.

I release Community Health Network and/or its agents and any person or entity, which provides information pursuant to this authorization, from any and all liabilities, claims, or law suits in regard to the information obtained from any and all of the sources used.

Driver’s License Number: ____________________________________________

Social Security Number: ___________ - __________ - __________

Date of Birth: ______________________________________________________

Month /Day/Year

Gender (check one):          □ Male          □ Female

Ethnicity (check one):        □ African American
□ Asian
□ Caucasian
□ Hispanic
□ Other_____________________
__________________________________________ ___________________________
Maiden and/or other names used:                                                                                   

Legal Name: ____________________ ___________________         _

__________________________________________
Last                                       First                                     Middle

__________________________________________
Signature                                                           Date

08/23/17
Charge Card Payment

Visa _____  Mastercard _____  Discover _____  American Express _____

Date: ________________________________

Name on Card: ________________________________

Number Imprinted on Card: ________________________________

Expiration Date on Card: ________________________________

Security Code on Card: ________________________________

Student’s Name: ________________________________

Daytime Phone Number: ________________________________

Nighttime Phone Number: ________________________________

Email Address: ________________________________

Amount to be Collected: ________________________________

Billing Address: ______________________________________

___________________________________________

___________________________________________

___________________________________________

Signature: ______________________________________

08/23/17