WENATCHEE VALLEY COLLEGE

EMT 151
Emergency Medical Technician

Course Description

This thirteen (13) credit program teaches students the roles and responsibilities of the Emergency Medical Technician according to the National EMS Education standards and requirements. Students develop skills in patient evaluation and other emergency medical procedures. Upon successful completion of this program, students are eligible to take the National Registry Exam to qualify for state certification after meeting the Washington state requirement of employment. For this course to be approved for Veterans benefits, Financial Aid, grants and scholarships, students must be enrolled in the Fire Science AAS-T degree.

Entrance Requirements

- Show proof of being at least 17 years of age at the beginning of the course enrollment (proof required). The WA State requirement for entrance into the EMT course is 17 years of age. Certification usually requires that you are 18 years of age.
- Provide a copy of high school diploma, GED equivalency, or college transcript showing high school completion.
- Have the physical strength to carry, lift, extricate, and perform similar maneuvers in a manner not detrimental to the patient, fellow emergency technicians, or self.
- American Heart Association Health Care Provider (HCP) card or American Safety & Health Institute Provider ASHI (HCP) card issued within 6 months of course start date.
- Successfully pass a background check
- Verification of required immunizations and accident insurance
- Applications need to be brought to WVC; incomplete applications will not be accepted.

Schedule

EMT class is offered winter quarter. The EMT course requires 100% completion of assigned computer-based learning activities and attendance in classroom, lab, and clinical rotation sessions. This course is offered in a hybrid format, combining face-to-face classroom instruction, practical skills labs, clinical skills rotations, and interactive computer based learning online.

Save the date:

EMS 151 Emergency Medical Technician

***Quarter:* ____________ *Year:* _______**

Complete this application and the forms that follow. Attach the required documentation and submit all forms in person to Rhonda Yenney. *You may forfeit the processing of this application if forms and/or documentation are incomplete.*

Name: __________________________________ Email Address: _________________________
First, Middle, Last

Mailing Address: ____
Street or P. O. Box *City* *State,* *Zip*

Phone Numbers: ____
Telephone *Cell Phone* *Alternate Telephone*

WVC Student Identification Number: ____

Are you at least 17 years old? ◯ Yes ◯ No Birthdate: ______________________
Month/Day/Year

Are you physically able to do work of an EMT? ◯ Yes ◯ No

Are you a High School graduate? ◯ Yes ◯ No GED? ◯ Yes ◯ No

Year you received your diploma or certificate: ____________________

FIRE DEPARTMENT AFFILIATION:
Provide the following information from your affiliated emergency agency.
NOTE: Participants who are *<u>not</u>* *affiliated have one year from the completion of this course to meet the affiliation requirement to be certified by the State of Washington.*

Agency/District______________________ Chief/Supervisor: ___________________ Phone ___________

Mailing Address________________________________ Chief/Supervisor Signature _________________

NOTE: Affiliated students must submit all attachments (current photo ID, high school diploma or GED certificate, verification of six immunizations, health insurance, whether or not the affiliating agency has the paperwork on file.)

Completion of this application does not guarantee admission to the EMS 151 course. Applications for the Wenatchee campus must be submitted in person to Rhonda Yenney, Allied Health Department. Applications will be reviewed to assure that the requirements for enrollment in the course have been met. If requirements have been met, you will be given a registration form to take to Registration.

COURSE PREREQUISITES

Background Check/Negative Drug Screen

Background Check

☐ Washington State law (RCW 43.43.832) permits businesses or organizations that provide services to children, vulnerable adults, or developmentally disabled persons to request criminal history records. Facilities used for clinical work experience require clearance prior to the student being allowed to work in the facility. The background check cannot be dated more than 45 days before the start of the program.

Students need to be aware that conviction of certain crimes may prevent completion of the clinical course requirements of the Program and may also prevent future licensing and employment in the health field.

Create an account at http://www.wenatcheevalleycompliance.com. Students are required to purchase the criminal check through this Complio website before acceptance into the program.

Negative Drug Screen

☐ Students must provide results of a standard, ten-panel drug screen, either urine-based or oral swab, dated not more than forty-five (45) days prior to the beginning of the Program.

Drug screens are required to be purchased through Complio. Purchase the drug screen along with the criminal check at http://www.wenatcheevalleycompliance.com.

Immunizations

Official documentation is required: Each record must be on the healthcare provider's letterhead, have the student's name, have the date of immunization, have the signature of the person administering the immunization, and the lot number of the vaccine administered.

Two-Step PPD

☐ An initial negative two-step PPD is required, which means that two (2) separate tuberculin skin tests have been placed one to three weeks apart. Each test is read 48 to 72 hours after it has been placed. This is a four-visit procedure. Documentation must show the dates and results of the tests, as well as the lot numbers of the vaccine. Students should not get any other vaccination with the first PPD.

Students with a positive PPD must provide documentation of a chest x-ray, treatment (if necessary), and a release to work in a healthcare setting from a doctor or healthcare provider.

Tuberculin skin tests are required each year (annual renewal) and must be placed and read within one year following the initial two-step PPD.

As some facilities now utilize the QuantiFERON® TB Gold Test in place of the PPD, WVC will accept this method. This does not require a two-step initial skin test; however, the test must be performed annually.

PPD Timeline:

Appointment with Healthcare Provider	Action	Time Interval
First appointment	Initial injection	
Second appointment	Read results	48 to 72 hours from date/ time of injection; cannot be prior to 48 hours or later than 72 hours.
Third appointment	Second injection	One to three weeks after initial injection; cannot be less than one week or more than three weeks.
Fourth appointment	Read results	48 to 72 hours from date/ time of injection; cannot be prior to 48 hours or later than 72 hours.

Hepatitis B Vaccine (*complete series of three [3] injections*)

☐ Students must have the first injection prior to entering the Program. Adults getting Hepatitis B vaccine should get three (3) doses, with the second dose given four (4) weeks after the first and the third dose five (5) months after the second. Your healthcare provider can tell you about other dosing schedules that might be used in certain circumstances. Positive titer (blood test) is acceptable.

Flu Vaccine

☐ Depending on the availability of flu vaccine, each student is required to provide documentation of flu immunization with the application.

CPR Card

☐ American Heart Association Health Care Provider (HCP) card or American Safety & Health Institute Provider ASHI (HCP) card issued within 6 months of course start date.

Medical Insurance *(pertains to student accidents during clinical experiences)*

☐ Clinical affiliates associated with WVC require that students provide proof of accident insurance. Students refusing to provide proof of accident insurance will not be allowed access to clinical agencies to complete clinical course work. Students must maintain this coverage throughout the Program to cover any accident that might occur while at a clinical site. Even though a clinical facility may provide necessary emergency care or first aid for an accident (i.e., needle stick), a clinical facility has no obligation to furnish medical or surgical care to any student. The student bears responsibility for the cost of such care, as well as for any follow-up care.

For students who do not have insurance, the WVC recommends the carrier approved by the Washington State Board of Community and Technical Colleges. The cost is approximately $45 per quarter. The student may enroll online at www.4health.ascensionins.com.

A copy of the student's current personal medical insurance OR a copy of the student's

Ascension receipt are to be submitted with this application.

Documentation of student immunization status is essential to ensure the health and safety of students and the patients/clients/residents in healthcare agencies that provide clinical learning experiences. Lack of compliance with any of these requirements will prevent you from entering the clinical area and completing your clinical training.

Wenatchee Valley College reserves the right to add to or modify these requirements as needed.

This packet will be on file in the Allied Health Office.

I certify with my signature that I have read and understand the above requirements and that the information above and documentation submitted pertaining to me is complete and accurate.

Date: ______________________ Signature: _____________________________________

***REMINDER*: Keep your original documents for your personal records.**

Student Disclosure Form

1. Have you ever been convicted of a crime?

   Yes_____ No_____

   If yes, please list the conviction(s) and the degree(s):
   ____

2. Do you have charges (pending) against you for any crime?

   Yes_____ No______

   If yes, please list the pending charge(s) and the degree(s):
   ____

3. Are you aware that you must provide a background check through Complio®?

   Yes_____ No_____

4. Do you understand that some criminal convictions may prevent you from completing a program of study?

   Yes_____ No_____

5. Do you understand that you need to provide documentation of specified immunizations or evidence of immunity to specified diseases in order to participate in most programs in Allied Health?

   Yes_____ No_____

6. Are you aware that you must provide a negative drug screen for most Allied Health programs?

   Yes_____ No_____

7. Do you understand that your behavior during the time of training for a particular occupation needs to comply with both the Wenatchee Valley College Student Code of Conduct (see the WVC Student Handbook) and the code of conduct/ethics/standards that regulate the occupation for which you will be trained?

   Yes_____ No_____

8. Do you understand that by breaking the code of conduct for an occupation or the WVC Student Code of Conduct you may be subjected to disciplinary action, including suspension from the program?

   Yes_____ No_____

9. Do you understand that there are procedures and policies at Wenatchee Valley College that govern student grievances and disciplinary actions?

   Yes_____ No_____

____ ________________________________

Signature Date Name (*printed legibly*)

Child and Adult Abuse Information Act Disclosure Pursuant to RCW 43.43.834

Answer each item. If the answer is YES to any item, indicate the charge or finding, the date, and the court(s) involved.

1. Have you ever been convicted of any crimes against children or other persons, as follows: aggravated murder; first or second degree murder; first or second degree kidnapping, first, second, or third degree assault; first, second or third degree rape of a child; first or second degree robbery; first degree arson; first degree burglary; first or second degree manslaughter; first or second degree extortion; indecent liberties; incest; vehicular homicide; first degree promoting prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment; child abuse or neglect as defined in RCW 26.44.020; first or second degree custodial interference; malicious harassment; first, second, or third degree child molestation, first or second degree sexual misconduct with a minor; patronizing a juvenile prostitute; child abandonment; promoting pornography; selling or distributing erotic material to a minor; custodial assault; violation of child abuse restraining order; child buying or selling; prostitution? ANSWER ______
   If YES, explain

2. Have you ever been convicted of crimes relating to the financial exploitation if the victim was a vulnerable adult, as follows: first, second, or third degree theft; first or second degree robbery: forgery? ANSWER _____
   If YES, explain

3. Have you ever been found guilty in any dependency action under RCW 13.34.030(2)(b) to have sexually assaulted or exploited any minor or to have physically abused any minor? ANSWER ____________________
   If YES, explain

4. Have you ever been found in any domestic relations proceeding under Title 26 RCW to have sexually abused or exploited any minor or to have physically abused any minor? ANSWER ______________________
   If YES, explain

5. Have you ever been found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person or to have abused or financially exploited any vulnerable adult? ANSWER _____________________
   If YES, explain

6. Have you ever been found in any protection proceeding under chapter 74.34 RCW, to have abused or financially exploited a vulnerable adult? ANSWER ____________________
   If YES, explain

Pursuant to RCW 9A.72.085, I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

**Your signature must be witnessed by a non-family member.*

____

Name (*Please print*) Signature Date

____

*Witness Signature Business or Organization Address

Personal Medical Record

Part I: General Information

Full Name:________________________________ Program: _________________________
(Please print)

DOB:____________________________________ Academic Year: ____________________

Current Address/Phone Number:

Address: ____
Address *City* *State* *Zip*

Phone Numbers: ____
Telephone *Cell Phone* *Alternate Telephone*

In case of emergency please notify:

Name:___________________________________ Phone: ___________________________

Part II: Health History

Date of last health examination: ____

Name of health care provider *(optional)*: ___________________________________

Please identify any health conditions/illnesses or injuries that required medical treatment (please check all those that apply):

- ◯ Heart Defect/Disease
- ◯ Hypertension
- ◯ Asthma or other respiratory condition
- ◯ Diabetes or other endocrine condition
- ◯ Seizure Disorder
- ◯ Neurological problem
- ◯ Bleeding or clotting disorder
- ◯ Musculoskeletal problem/condition
- ◯ Any infection within last year
- ◯ Any traumatic injury within last year
- ◯ Mental and/or emotional condition
- ◯ Substance abuse
- ◯ Other

Further explanation of any items that are checked: ______________________________________

____

Personal Medical Record *(Cont'd.)*

Do you have any allergies? If yes, please specify: ____
____

Please list all medications that you take regularly: ____
____

Part III: Statement of Ability to Function as a Student in an Allied Health Program:

	Yes	No
Do you have a visual impairment?	◯	◯
If so, is it corrected?	◯	◯
Do you have a hearing impairment?	◯	◯
If so, is it corrected?	◯	◯
Can you list up to fifty (50) pounds?	◯	◯
Can you carry up to twenty (20) pounds?	◯	◯
Can you sit for four (4) hours?	◯	◯
Can you stand and/or walk unassisted for up to twelve (12) hours?	◯	◯
Can you use both hands?	◯	◯

Please rate your ability to cope with stressful situations:	Always	Usually	Not Always	Seldom
I am able to cope with stres	◯	◯	◯	◯

Wenatchee Valley College
Allied Health Department
Health Care Provider Statement/Medical Release

Prior to entrance into a Health Sciences program, a medical release must be completed by your health care provider. If at any time during the program, your health status changes, you must have your health care provider complete the medical release form.

All Allied Health students must be physically, emotionally, and academically able to safely demonstrate completion of all required learning activities. Learning activities include successful completion of course, clinical, and theory objectives in order to successfully complete the curriculum. All students must submit the health care provider statement or medical release, medical history, and student physical ability requirements. Allied Health students will be treated respectfully regardless of race, color, national origin, gender, age, religion, or disability. In turn, Allied Health students will treat their clients respectfully regardless of race, color, national origin, gender, age, religion, or disability. Wenatchee Valley College provides reasonable accommodation and services to otherwise qualified students who are physically and learning disabled unless making the accommodation poses an undue hardship on the college or jeopardizes client safety.

Allied Health students will be in clinical courses, requiring the safe application of both gross and fine motor skills, as well as critical thinking skills. All of these skills are inherent elements of clinical practice. Usual and required activities routinely conducted by students include care for clients that range from ambulatory to comatose, and involve all age ranges from premature infants to gerontology clients. There always exists potential exposure to communicable diseases and other pathogens.

STUDENT INSTRUCTIONS: I understand the student academic role and clinical performance requirements and agree that I have the primary responsibility of my own health status. I agree that I will not knowingly place myself, clients or others in unsafe situations based upon my physical, mental, or emotional limitations. I have completed and signed the physical abilities requirements form. I authorize my health care provider to release to Wenatchee Valley College Allied Health Programs the information requested below concerning my health status. If I am not truthful or falsify the health policy documents, I understand I will be withdrawn from the Program.

Printed name of student:

Signature of student: Date:

Health Care Provider Instructions: Please **complete the following questions** with the understanding of the academic role and clinical performance requirements of Allied Health students. Please do not attach any medical records.

1. Does the student have any limitations identified on the medical history questionnaire or disabilities that would interfere with the performance of the academic or clinical requirements specified above on this form? If yes, specify.

2. Based upon question #1, what special accommodations are medically necessary to assist the student with academic and clinical performance?

3. State any instructions or limitations with which the student has been advised to comply.

____
Signature of Health Care Provider (credentials) Date

____
Print Name of Health Care Provider Office Address (include city, state, zip)

Note: The signatures of both the student and health care provider are required for admission. The names and information must be legible to be accepted. Illegible documents will be returned to the student. Office (509) 682-6660/ Fax (509) 682-6661.

Wenatchee Valley College
Allied Health Department
Medical History Questionnaire

Name: ______________________________________ Date: ____________________________
(Last First Middle)
Home Address: ______________________________ Phone: ___________________________

Gender: ____________________________________ Date of Birth: ______________________

A. Check either yes or no; give details of a "yes" answer in section B that follows. *Being untruthful or withholding information will result in dismissal from the Allied Health Program.*

Have you ever been treated for conditions or had indications of:

	Yes	No		Yes	No
1. Eye/vision problems			15. Skin rashes or eczema		
2. High blood pressure			16. Fainting or dizziness		
3. Tuberculosis or lung disease			17. Head injury		
4. Asthma			18. Convulsions/Seizures		
5. Diabetes			19. Varicose veins		
6. Emphysema			20. Kidney/bladder problems		
7. Epilepsy or seizure disorder			21. Allergies		
8. Arthritis/Rheumatism/Bursitis			22. Hemorrhoids		
9. Disease or pain of bones/joints			23. Hepatitis		
10. Ear problems			24. Psychiatric problems		
11. Muscle spasms			25. History of substance abuse		
12. Reaction to medications			26. Anemia/blood disorders		
13. Reaction to chemicals			27. Heart problems		
14. Neck, shoulder, or back problems					

B. List below full details to questions answered "YES" in Section A, above. Use a separate sheet of paper if needed. A medical release for any of the above will be required for admission. Any other conditions will be considered individually and require a medical release.

Question #	Condition/Treatment/Management	Date

C. Do you take medicine regularly? Yes ☐ No ☐ If yes, list all prescribed and over-the-counter or herbal medications and reason for taking (use a separate sheet if needed):

____
____
____
____

Wenatchee Valley College
Allied Health Department
Physical Abilities Requirements

Student Name: ____

R: Regularly O: Occasionally			
Abilities	R	O	**Measurable Descriptor**
Vision: Corrected or Normal	X		Ability to read syringes, labels, instructions, and equipment
Color Vision	X		Color coded equipment
Hearing	X		Ability to hear through some equipment and noisy environments
Touch Temperature Discrimination	X		Palpation pulses & discriminate temperature & sensation; Use equipment requiring fine motor skills
Smell	X		Differentiate body odors, drainage, skin, and stool odor
Finger Dexterity/	X		Manipulation of equipment, dressings, IV and other functions requiring finger dexterity; assessment
Intelligible oral communication	X		Communication with clients, staff members, peers and faculty
Appropriate non-verbal communication	X		Therapeutic communication with client, rapport and trust with client and health care team
Pushing	X		Lbs/ft: 100, equipment, carts with and without clients
Pulling	X		Lbs/ft: 50, equipment, and client carts
Lifting	X		Lbs/ft: 50, clients, equipment, and supplies
Floor to waist	X		Lbs 75: 3 man lift of patients
Reaching forward	X		Moving clients and equipment
Carrying	X		Lbs 50
Standing and Walking	X		Long periods, up to eight hours
Sitting	X		Infrequent and short periods, break and lunch
Stooping/Bending	X		Infrequent and short periods; adjusting equipment
Kneeling/Crouching		X	Infrequent and short periods; adjusting equipment
Running		X	Infrequent, emergency situations
Crawling		X	Short periods, emergency, adjusting equipment
Climbing	X		Infrequent, patient care activities
Stairs (ascending/descending)		X	Infrequent, emergency situations
Turning (head/neck/waist)	X		Frequent extended periods; may position for long periods
Repetitive arm movement	X		Key Boards/Computer

I have read, understand, and accept the above working conditions expected of an Allied Health student in the academic and clinical setting and certify that I am able to meet these requirements.

____
Student Signature

____
Date

Wenatchee Valley College
Allied Health Department
Student Health Statement/Medical Release Form

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Allied Health students will be in clinical courses, requiring the safe application of both gross and fine motor skills, as well as critical thinking skills. All of these skills are inherent elements of practice. Usual and required activities routinely conducted by students include care for clients that may be ambulatory or comatose and involves all age ranges from premature infants to gerontology clients. Required abilities are walking, standing for up to eight hours, bending, reaching, turning, listening, observation, and moderate to heavy lifting (at least 50 pounds). There always exists potential exposure to communicable diseases and other pathogens.

STUDENT INSTRUCTIONS: I understand the student academic role and clinical performance requirements and agree that I have the primary responsibility of my own health status. I agree that I will not knowingly place myself, clients, or others in unsafe situations based upon my physical, mental, or emotional limitations. I have completed and signed the physical abilities requirements form. I authorize my health care provider to release to Wenatchee Valley College Allied Health Program the information requested below concerning my health status. Printed name of student:	
Signature of student:	Date:

Note: This form with the student's signature is required prior to return to clinical following absence due to health problems or changes in health status. The faculty reserves the right to request the student to complete a student health statement in the event the student demonstrates evidence of clinical performance affected by physical, emotional, or mental limitations.

Office Use Only	
Date and Time Received:	
Program Director:	Clinical Site
Comments:	
Approval for class/clinical ☐yes ☐no	Program Director Signature:

Student Release Form

The clinical facilities you will be working in may require copies of your abuse statement, background check and immunization records. Please sign and return this form to the WVC Allied Health Department as your approval for releasing this information.

If requested by the clinical facility to which I have been assigned, you have my permission to release my abuse statement, background check, and immunization records to that clinical facility.

Student Name: ______________________________ Program: ________________________________
(Please print)

Student Signature: ___________________________ Date: ___________________________________

Student Confidentiality Statement

Student Name: ______________________________ Program: ___________________________
(Please print)

Address: ____
(Street or P. O. Box) *City* *State* *Zip*

Confidentiality Statement: I understand that, as an Allied Health student at Wenatchee Valley College, I am not considered to be an employee of the clinical agency where I may participate in clinical learning experiences. I agree to abide by all Wenatchee Valley College policies, procedures, standards, and regulations that guide my conduct. I understand and agree that, in the performance of my duties as a student at Wenatchee Valley College, I must hold medical information in confidence. Further, I understand that intentional or involuntary violation of confidentiality may result in punitive action, immediate termination of access to further data, and the immediate termination of my participation in any clinical learning experience at Wenatchee Valley College.

____
(Student signature)

____
(Date)

Community Relations
P: 509.682.6420 / F: 509.682.6401
1300 Fifth Street
Wenatchee, WA 98801

Wenatchee Valley College (WVC) may take and use photographs of me or excerpts of statements I provided to be used for promotional purposes, such as college publications, the Web site, displays, video presentations, and advertisements, with the understanding that my image and statements will be used to promote WVC only. I do this willingly, expecting no compensation or gratuity of any kind from WVC.

Name: ______________________________________ E-mail: ______________________________
(Please print)

Address: ____
(Street or P. O. Box) *City* *State* *Zip*

Telephone Numbers: ____
Telephone *Cell phone* *Alternative phone*

Signature: ___________________________________ Date _______________________________