

# **EMT Application**

## **Emergency Medical Technician (EMT) Application**

### **Is this the right application for me?**

*If you answer "True" to **ALL** of the following questions, then this is the appropriate application for you.*

1. I **DO NOT** currently hold an Emergency Medical Technician (EMT) certification in the state of Texas or in any other state in the United States.  
☐ True  
☐ False
2. I **DO NOT** currently have a pending Emergency Medical Technician (EMT) certification application with the Texas Department of State Health Services or any other state licensing agency.  
☐ True  
☐ False
3. I have **NOT successfully completed** an EMT course at this school or at any other school in the last 2 years.  
☐ True  
☐ False
4. I am over 17 years' old.  
☐ True  
☐ False
5. I am a high school senior or have a high school diploma or equivalent *and* can provide the college a *valid* transcript as proof.  
☐ True  
☐ False
6. I have completed the Apply Texas application and been accepted to Alvin Community College as a student.  
☐ True  
☐ False
7. I have a clear background or meet the criteria outlined on Pages 9-10 of this packet.  
☐ True  
☐ False
8. I do not abuse drugs or alcohol and will successfully pass the required drug screening.  
☐ True  
☐ False
9. I am confident that I am able to meet all of the functional and physical criteria outlined on Pages 5-8.  
☐ True  
☐ False
10. I am able to provide valid documentation of all vaccinations listed on Page 12 of this packet.  
☐ True  
☐ False
11. I have a valid Texas driver's license or valid Texas state identification card.  
☐ True  
☐ False
12. I understand that there are associated fees outside of tuition, books, and course fees that financial aid does not cover, and I have the financial means to cover these costs. (See Page 15)  
☐ True  
☐ False

# **EMT Application Checklist**

***Each of the following documents must be turned in by the posted deadline to the EMT Program administrative assistant in S108. Any missing documents constitutes an incomplete application. Incomplete applications are not considered for entry into the Program.***

- ☐ Completed “Is this the right application for me?” Page
- ☐ EMT Application Demographics Page
- ☐ Vaccination Acknowledgement Form
- ☐ Background and Drug Screening Acknowledgement Form
- ☐ Functional and Physical Requirements Acknowledgement Form
- ☐ Completed Personal Statement Page
- ☐ 3 Completed and Sealed letters of Recommendation

# EMT Application Demographics Page

Last Name:		First Name:		Middle Initial:	Preferred Name:
Mailing Address:					
Street, PO Box, Rural		Apt/Unit/Tlrl #	City	County	State Zip
Permanent/Physical Address (If different from above):					
Street, PO Box, Rural		Apt/Unit/Tlrl #	City	County	State Zip
Home Phone:		Cell Phone:		Work Phone:	
Emergency Contact Name:		Emergency Contact Phone Number:		Emergency Contact Relationship:	
ACC Student Email Address:					
Citizenship: <input type="checkbox"/> U. S. Citizen <input type="checkbox"/> Permanent Resident Alien <input type="checkbox"/> International Student					
Country of Citizenship:			Resident Card Number (if applicable):		
<input type="checkbox"/> High School Graduate   OR <input type="checkbox"/> GED Certificate		School Name/City/State:		Date of Graduation:	
Are you currently enrolled in a major college or university? <input type="checkbox"/> Yes <input type="checkbox"/> No      If so, please list the name, city, & state:					
<b>Colleges or Universities Attended</b>					
School Name/City/State:		Major &/or Degree Earned:		Dates Attended:	
School Name/City/State:		Major &/or Degree Earned:		Dates Attended:	
School Name/City/State:		Major &/or Degree Earned:		Dates Attended:	
Have you previously enrolled in an allied health program?	Program Type:	Institution Name:	City/State:	Dates Attended:	
<input type="checkbox"/> YES <input type="checkbox"/> NO					
Do you currently hold any healthcare certification(s)?		If so, please list all credentials you currently hold:			
<input type="checkbox"/> YES <input type="checkbox"/> NO					
Which pathway are you most interested in?					
<input type="checkbox"/> EMT Certificate <input type="checkbox"/> Advanced EMT Certificate <input type="checkbox"/> Paramedic Certificate <input type="checkbox"/> AAS Paramedic <input type="checkbox"/> Other (Please describe below)					
I am a returning Alvin Community College Emergency Medical Technology Student: <input type="checkbox"/> YES <input type="checkbox"/> NO					
If you are a returning student, when were you last enrolled in the Program?			Semester:	Year:	

## EMT Application

### Vaccination Acknowledgement

I, \_\_\_\_\_, acknowledge that the Alvin Community College  
(Print your First and Last Name)  
Emergency Medical Technology Program clinical affiliates require all Program students entering their facilities to have documented proof of receiving the following vaccinations (in their entirety of series) or documented proof (titer) of immunity:

- Measles, Mumps, and Rubella
- Varicella
- Hepatitis B
- Negative Tuberculosis Test
- Tetanus
- Meningitis (for students who are 17 years to 22 years old)
- Flu

I, \_\_\_\_\_, acknowledge that the Program clinical affiliates do  
(Print your First and Last Name)  
not allow declinations, *for any reason*, for any of the above listed vaccinations/testing.

I, \_\_\_\_\_, acknowledge that if I do not provide proof of  
(Print your First and Last Name)  
immunity of the above listed communicable diseases, I will not be permitted to participate in clinical rotations and, therefore, will not achieve all of the course completion requirements needed to take the EMT, Advanced EMT, or Paramedic certification exam.

\_\_\_\_\_  
(Print your First and Last Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

## EMT Application

### Background and Drug Screening Acknowledgement

I, \_\_\_\_\_, acknowledge that the Alvin Community College  
(Print your First and Last Name)

Emergency Medical Technology Program requires each enrolled student to submit to a comprehensive background check once a year for the duration of enrollment in the Program. I acknowledge that I am responsible for the cost of the background screening. I acknowledge that a negative background screen that is not supported with approving documentation from the Texas Department of State Health Services will result in immediate mandatory withdrawal from all EMSP courses.

\_\_\_\_\_  
(Print your First and Last Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

I, \_\_\_\_\_, acknowledge that the Alvin Community College  
(Print your First and Last Name)

Emergency Medical Technology Program requires each enrolled student to submit to mandatory drug screening each semester I am enrolled in an EMT Program clinical course (EMT, AEMT, and Paramedic). I acknowledge that I am responsible for the cost of each drug screen. I acknowledge that I have read and fully understand the Allied Health Programs Drug Screening Policy.

\_\_\_\_\_  
(Print your First and Last Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

## EMT Application

### Functional and Physical Requirements Acknowledgement Form

I, \_\_\_\_\_, acknowledge that I have read, in their entirety, and  
(Print your First and Last Name)  
understand the Functional Job Description, Qualifications to Work as an EMS Professional, EMS Professional Competency Areas, Description of Emergency Medical Services Tasks, and the Physical Guidelines sections of this document. After reading these sections, I do hereby attest that I can perform all of the functional and physical requirements to complete the course and work as an EMS professional.

\_\_\_\_\_  
(Print your First and Last Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)



**EMERGENCY MEDICAL TECHNOLOGY PROGRAM**

**PERSONAL STATEMENT**

Please attach a separate sheet of paper if necessary. Please write legibly.

1. Please explain in your own words why you wish to enroll in the EMT course?


2. Please tell us about any experiences in your life that have led you to a career in EMS?






## EMERGENCY MEDICAL TECHNOLOGY PROGRAM

### Letter of Recommendation

I. To the applicant:

This form is to be given to a person who is familiar with your academic, professional, or personal qualifications.  
(i.e. Employer, supervisor, counselor, instructor, **professional, not personal**)

Applicant \_\_\_\_\_  
(Last Name) (First Name) (Middle Name)

Address \_\_\_\_\_

Under the Buckley Amendment, students at Alvin Community College are permitted to see their academic records under certain conditions. I hereby **waive** ☐ **retain** ☐ (check one) the rights thus granted me to see this letter of recommendation should I become a student at Alvin Community College – Emergency Medical Technician Program.

\_\_\_\_\_  
Signature of Applicant Date

To \_\_\_\_\_  
(Applicant to fill in name of person providing reference)

**PLEASE USE THIS FORM ONLY FOR YOUR RECOMMENDATION  
MAIL TO ADDRESS AT BOTTOM, OR  
RETURN WITH APPLICANT IN SEALED ENVELOPE**

- II. The above named person is applying for admission to the Emergency Medical Technician Program, Alvin Community College, and has given your name as a reference. Would you please comment on the applicant's major strengths and weaknesses with regard to a career in health care? Please supply any additional information which might help us in considering the applicant and return this recommendation form to the address listed at the bottom of this form.

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Acquaintance with Applicant:

1. How long and in what capacity have you known this applicant? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**COMMENTS:** (Use an extra sheet of paper if needed). Please add any descriptive comments that will aid in providing a complete picture of the applicant's abilities and potential as a trainee and health care professional.

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**III. Professional Appraisal:** (Please check the category which best indicates your evaluation of the applicant in terms of the listed characteristics.)

Characteristics	(3) Superior	(2) Above Average	(1) Average	No Basis for Evaluation **
A. Academic Potential				
B. Leadership				
C. Professional Competence *				
D. Sense of Responsibility				
E. Ability to Work with People				
F. Rapport with Patients *				
G. Ability to Adapt to New Situations				
H. Ability to Work Independently				
I. Reliability				
J. Oral Communication				
K. Written Communication				
L. Ability to Analyze Problems and Solve them Effectively				

\* This category should be completed only by those who have had an opportunity to observe the applicant in a health setting.

\*\* This indicates you have not had the opportunity to observe the applicant in a situation demonstrating this characteristic

**IV. Recommendation for Acceptance:**

- ( ) Strongly recommend                      ( ) Recommend with reservations as noted in the comment section  
( ) Recommend                                      ( ) Do not recommend

**Please type or print**

Your Name: \_\_\_\_\_  
 Organization: \_\_\_\_\_  
 City: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Signature: \_\_\_\_\_

Title: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Date: \_\_\_\_\_

**Please note:** It is not possible to thank each individual personally for completing a recommendation form. We want you to know, however, that we are aware of the time required and both we and the applicant are most appreciative of your response. Please return this signed form to the applicant in a sealed envelope or to the following address:

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**Please type or print**

Your Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

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( ) Recommend                                      ( ) Do not recommend

**Please type or print**

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 Organization: \_\_\_\_\_  
 City: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
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