ADMISSION PROCESS FOR PARAMEDIC PROGRAM

1. Register as a student at Lakeland if you have not done so already.

Starting with the fall semester of 2012, all students must take and pass with a letter grade of C or better either:

HLTH 1238 Human Body
or
BIO 2210 Anatomy/Physiology 1 and BIO 2220 Anatomy/Physiology 1

The course can be taken concurrently with EMTS 2011 but must be done so during the first 8 weeks of the semester.

2. Complete a Paramedic Program Admission Application. The application fee is $50.00 payable at the Cashier's Office. The fee helps pay for practical testing and lab supplies. The application forms may be obtained from:
   - Admissions, at the main campus (440) 525-7117
   - Debbie Hermetet, 3rd floor reception area of the H building, main campus (440) 525-7022

3. Provide **copies of your CPR card (American Heart Association Healthcare Provider) and Ohio EMT certification card** when you submit your Paramedic Program Admission Application.

4. Sign up to take the Test of Essential Academic Skills Test- Allied Health version (TEAS-AH) **prior to the first day of class**. There is a $50.00 non-refundable fee for the test. The fee covers the cost of the test and proctor fees. The fee must be paid prior to registering for the test. Students can obtain the cashier's form from the admissions or cashier's office. The form should be taken to the cashier's office in Building A along with cash, check or credit card. Students will receive a receipt and one will be sent to the health technologies office. Students who receive financial aid should call the financial aid office at 440.525.7070 to find out if financial aid can be applied to the cost of the test. Students who receive benefits from the Board of Vocational Rehabilitation (BVR) or Workforce Investment Act (WIA) should contact the counselor from that agency to determine if the cost of the test will be included in their funding package.

   Once the fee has been paid, students must register through Lakeland's Learning Center. Students may register in person in room A-1044 or by phone at 440.525.7019.

5. Students will be required to complete a Criminal Background Check and Drug Screen prior to being permitted to attending clinical sites. The cost of the combined test is $111.00. A copy of the request is attached

6. Students will also be required to complete the Mandatory Student Health Requirements Form prior to attending clinical sites. The form is to be completed by your personal physician and returned to the Health Services- S-011. A copy of the form is attached.

7. Once all of the steps above have been completed, your application will be processed and you will receive a letter notifying you of your acceptance into the Paramedic Program. You will not need to register for the Beginning Paramedic Course (EMTS 2011) as you will automatically be enrolled upon verification of the documents as submitted.

For further information, feel free to contact:
Joe Cooper, Paramedic Program Director- (440) 525-7693
jcooper@lakelandcc.edu

(Revised 11/16)

LAKELAND COMMUNITY COLLEGE

BACKGROUND CHECK & DRUG SCREEN

Before Starting:

- A valid email is REQUIRED-(Example: jsmith2@mail.lakelandcc.edu)
- You must be near a printer to print necessary forms for fingerprint & drug test.
  - You will only have **3 days to complete your drug test**
- **Have credit card ready to pay, you will be prompted to pay on the website (Visa, MC, Amer Express)**

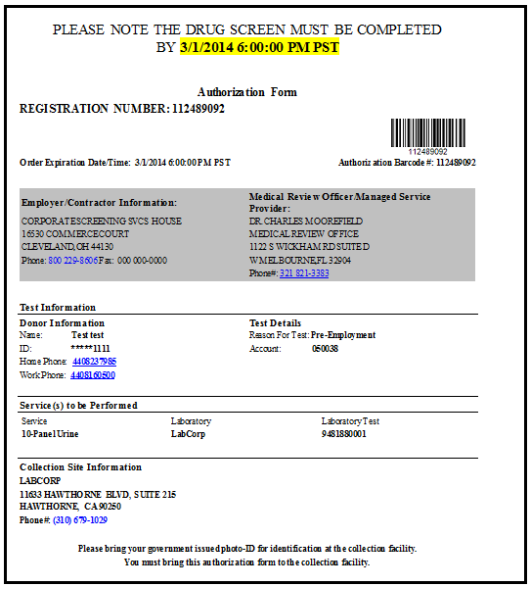
Getting Started:

1. Log onto our website at **www.VerifyStudents.com**
2. Use this special promotional code: *lakelandbgdt*
3. Complete profile & e-sign forms as they appear
4. **Schedule your drug test and print Authorization Form & Fingerprint Control Form** (sample forms shown below)

After completing online process:

1. Drug testing: go to collection site listed on Authorization Form (sample show below – on the left)
   - Bring ePassport & government photo ID, e.g. – driver's license

2. Fingerprinting
   - Bring Fingerprint Control Form & government photo ID to your school's designated fingerprint location (Human Resources Dept., Room C-2089, hours and days available – M-F 7:00 a.m. – 4:00 p.m.). If you are unable to come on any of those dates/time, you can go to Corporate Screening's office, 16530 Commerce Ct, Middleburg Hts. M-F 8:30 – 5:00 no apt. needed, or 5:00 – 7:30 by apt. only to have it completed. Remember to take your Fingerprint Control Form and government photo ID.



PLEASE NOTE THE DRUG SCREEN MUST BE COMPLETED BY 3/1/2014 6:00:00 PM PST

Authorization Form

REGISTRATION NUMBER: 112489092

112489092

Order Expiration Date/Time: 3/1/2014 6:00:00 PM PST — Authorization Barcode #: 112489092

Employer/Contractor Information:	Medical Review Officer/Managed Service Provider:
CORPORATESCREENING SVCS HOUSE 16530 COMMERCECOURT CLEVELAND,OH 44130 Phone: 800 229-8606 Fax: 000 000-0000	DR.CHARLES MOOREFIELD MEDICAL REVIEW OFFICE 1122 S WICKHAM RD SUITE D WMELBOURNE,FL 32904 Phone#: 321 821-3393

Test Information

Donor Information		Test Details	
Name:	Test test	Reason For Test:	Pre-Employment
ID:	*****1111	Account:	050038
Home Phone:	4408237586		
Work Phone:	4408160650		

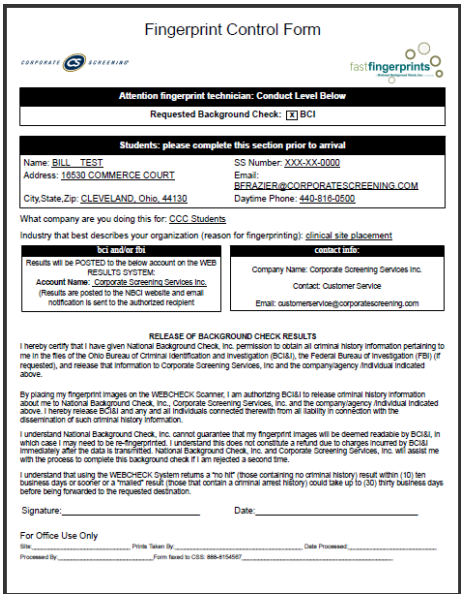
Service(s) to be Performed

Service	Laboratory	Laboratory Test
10-Panel Urine	LabCorp	9481880001

Collection Site Information

LABCORP
11683 HAWTHORNE BLVD, SUITE 215
HAWTHORNE, CA 90250
Phone#: (310) 679-1029

Please bring your government issued photo-ID for identification at the collection facility.
You must bring this authorization form to the collection facility.



Fingerprint Control Form

CORPORATE SCREENING — fastfingerprints

Attention fingerprint technician: Conduct Level Below

Requested Background Check: [X] BCI

Students: please complete this section prior to arrival

Name: BILL TEST
Address: 16530 COMMERCE COURT
City,State,Zip: CLEVELAND, Ohio, 44130
SS Number: XXX-XX-0000
Email: BFRAZIER@CORPORATESCREENING.COM
Daytime Phone: 440-816-0500

What company are you doing this for: CCC Students

Industry that best describes your organization (reason for fingerprinting): clinical site placement

bci and/or fbi	contact info:
Results will be POSTED to the below account on the WEB RESULTS SYSTEM: Account Name: Corporate Screening Services Inc. (Results are posted to the NBCI website and email notification is sent to the authorized recipient	Company Name: Corporate Screening Services Inc. Contact: Customer Service Email: customerservice@corporatescreening.com

RELEASE OF BACKGROUND CHECK RESULTS

I hereby certify that I have given National Background Check, Inc. permission to obtain all criminal history information pertaining to me in the files of the Ohio Bureau of Criminal Identification and Investigation (BCI&I), the Federal Bureau of Investigation (FBI) (if requested), and release that information to Corporate Screening Services, Inc and the company/agency /individual indicated above.

By placing my fingerprint images on the WEBCHECK Scanner, I am authorizing BCI&I to release criminal history information about me to National Background Check, Inc., Corporate Screening Services, Inc. and the company/agency /individual indicated above. I hereby release BCI&I and any and all individuals connected therewith from all liability in connection with the dissemination of such criminal history information.

I understand National Background Check, Inc. cannot guarantee that my fingerprint images will be deemed readable by BCI&I, in which case I may need to be re-fingerprinted. I understand this does not constitute a refund due to charges incurred by BCI&I immediately after the data is transmitted. National Background Check, Inc. and Corporate Screening Services, Inc. will assist me with the process to complete this background check if I am rejected a second time.

I understand that using the WEBCHECK System returns a "no hit" (those containing no criminal history) result within (10) ten business days or sooner or a "mailed" result (those that contain a criminal arrest history) could take up to (30) thirty business days before being forwarded to the requested destination.

Signature:_____ Date:_____

For Office Use Only

Site:_____ Prints Taken By:_____ Date Processed:_____

Processed By:_____ Form faxed to CSS: 888-8154567_____

Viewing the status of your background:

- Click on "Login/Report Retrieval," enter your login information, and the site will let you know if your background is pending or complete.
- Once your background is complete, you may save or print your report. You also have the option to e-mail the report to someone else.

PLEASE NOTE: If you have any questions, call Customer Support at 1-800-229-8606, option 4.

9/2014

Please note that this information is for the sole purpose of background screening for this school only. Unauthorized use of our service is prohibited

LAKELAND COMMUNITY COLLEGE

Paramedic STUDENT HEALTH RECORD

— PLEASE PRINT ALL ENTRIES —

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	SS#	GENDER

STREET ADDRESS	CITY	COUNTY	STATE	ZIP CODE	PHONE

PERSON TO CONTACT IN CASE OF EMERGENCY	PHONE	ALTERNATE PHONE

STUDENT HEALTH HISTORY

This portion of the form is to be filled out COMPLETELY before submitting to your physician.

CONDITIONS	Do you NOW have any of these conditions?		If yes, age at which you developed any of the conditions listed.			Indicate by check if blood relative has had any of these conditions.			
	YES	NO	12 or under	13-18	19 or over	FATHER	MOTHER	BROTHER	SISTER
1. Cancer									
2. Diabetes									
3. Heart Disease									
4. Kidney Disease									
5. Nervous or Emotional Condition									
6. Tuberculosis									
7. Asthma									
8. Convulsions									
9. Epilepsy									
10. Hay Fever									
11. Headaches (Frequent)									
12. Hernia									
13. Menstrual Cramps (Severe)									
14. Mononucleosis									
15. Pneumonia									
16. Polio									
17. Rheumatic Fever									
18. Scarlet Fever									

CHECK WHICH LEVEL OF HEALTH APPLIES TO THE FOLLOWING:	EXCELLENT	FAIR	POOR	DECEASED
YOURSELF				
FATHER				
MOTHER				
SPOUSE				

CHECK YES OR NO FOR EACH OF THE FOLLOWING, AND/OR FILL-IN BLANKS AS INDICATED.	YES	NO
Have you ever had any significant injuries or operations? If so, explain and give dates: _____	❑	❑
Are you allergic to any drugs or medication? If so, name: _____	❑	❑
Are you allergic to insect bites?	❑	❑
Are you allergic to pollen?	❑	❑
Do you take any kind of drug(s) or medication(s) frequently? If so, name: _____	❑	❑
Do you have any physical impairment such as loss of vision that will require preferential seating? If so, name: _____	❑	❑
Do you have any voice or speech difficulties which make it difficult for others to understand what you say?	❑	❑
Do you have any difficulty hearing what others say?	❑	❑
Are you covered by any hospitalization insurance? If so, give company name and policy number: _____	❑	❑

Additional comments: _____

_____

Student has no physical or mental illness or condition which, even with reasonable accommodation on the part of the Hospital or Affiliating School, could be detrimental to the welfare of, or interfere with, the care of any Hospital's patients.
I hereby give consent to the College Health Services to release a copy of this Health Record to the Paramedic Director and the Dean of Science and Health and Clinical sites.

_____ _____

Student's Signature ***Date***

HEALTH EXAMINATION BY PHYSICIAN

Doctor: Please complete both sides of form.

LAST NAME (PLEASE PRINT) _____ FIRST NAME _____ M.I. _____

REQUIRED

HEIGHT	WEIGHT	B/P / PULSE	URINALYSIS	BLOOD
			Albumen _____ Sugar _____	CBC Lab Report — **MUST** — be attached to this form.

RECOMMENDED

VISION	HEARING
Right _____ Left _____ Corrected Right _____ Left _____	Right _____ Left _____

CHECK NORMAL OR ABNORMAL FOR EACH OF THE FOLLOWING. ENTER "N.E." IF NOT EVALUATED

	NRML	ABNRML		NRML	ABNRML		NRML	ABNRML
1. HEAD, NECK, FACE and SCALP			10. HEART (Include estimate of cardiac function)			16. UPPER EXTREMITIES		
2. NOSE and SINUSES						17. LOWER EXTREMITIES		
3. MOUTH and THROAT			11. VASCULAR SYSTEM (Include varicosities)			18. FEET		
4. TEETH and GINGIVA						19. SPINE (Other musculo-skeletal)		
5. EARS – GENERAL (Canals, etc.)			12. ABDOMEN AND VISCERA (Include hernia)					
6. DRUMS (Perforations, etc.)						20. SKIN and LYMPHATIC (Include acne)		
7. EYES (Lids, Conjunctiva, etc.)			13. ANO-RECTAL and PILONIDAL					
8. PUPILS and OCULAR MOTION			14. ENDOCRINE SYSTEM			21. NEUROLOGIC		
9. LUNGS, CHEST and BREASTS			15. G.U. SYSTEM			22. PSYCHIATRIC		

Give the corresponding number of the abnormality and the details which accompany it. (Please print or type.)

CHECK YES OR NO FOR EACH OF THE FOLLOWING, AND/OR FILL-IN BLANKS AS INDICATED.

	YES	NO
Student MAY participate in unlimited physical education and intramural activities. ..... If limited, to which activities and why? (Please be specific.) _____	❑	❑
Is the student receiving medication regularly?	❑	❑
If yes, which medications(s)? (Please be specific.) _____ Is there any physical condition (e.g., epilepsy, fainting, diabetes, paralysis) which would limit the student's participation in hospital, classroom or clinical activities?	❑	❑

If yes, please explain.) _____

— IMMUNIZATION SECTIONS ARE TO BE COMPLETED BY A PHYSICIAN. —

REQUIRED IMMUNIZATIONS & TITERS (Dates MUST be in MM/DD/YY format.) ATTACH LAB REPORTS

Tdap (Tetanus, Diptheria, & Pertussis) Titer Date: _____ Flu Vaccination (by injection only) Date: _____

Rubella (German Measels) Titer Date: _____ A copy of the lab results must be attached

Rubeola Vaccine (Measels) Titer Date: _____ A copy of the lab results must be attached

Varicella (Chicken Pox) Titer Date _____ A copy of the lab results must be attached

Hepatitis B, dates of 3 doses of vaccine: 1st _____ 2nd _____ 3rd _____ **or attach lab results for a positive titer**

Or sign a HepB declination/refusal form (the form can be obtained at Lakeland Health Services)

2 step TB test: date placed: _____ date read: _____ date placed: _____ date read _____ Results _____
(it takes at least 9 days to complete a 2 step TB skin test)

or

A QuantiFERON gold blood: *A copy of the lab report **MUST** be attached*

Recommended: (not required)

Polio Vaccine Date and Type of Basic Series: _____, _____, _____ or titer Date _____ A copy of lab results must be attached

PLEASE TYPE OR PRINT. ***PLEASE ATTACH CBC.***

Physician's Name: _____ ***Physician's Signature*** _____ ***Date of Exam***

Address:

Phone:

NOTE: Student must bring this form to Health Services, S011, Lakeland Community College, 7700 Clocktower Drive, Kirtland, OH 44094-5198.