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
   - The application can be obtained online at https://lakelandcc.edu/web/about/694

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. Submit a completed Paramedic program application to the EMTS program director at dsolomon1@lakelandcc.edu An interview session will be scheduled.

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 $112.25. 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 Paula Pastor-Hinkel at ppastor-hinkel@lakelandcc.edu
   Background check, drug screen, and physical exam forms are attached.

6. Once all the steps above have been completed, your application will be processed, and you will receive a letter notifying you of your status 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.

7. For further information, feel free to contact:
   Daniel Solomon, Paramedic Program Director- (440) 525-7693
   dsolomon1@lakelandcc.edu

Please contact your program director for deadlines and start dates as to when to begin this process.

BACKGROUND CHECK & DRUG SCREEN

Please read carefully and follow ALL steps.
NOTE: Use a laptop or desktop computer to complete this requirement.
Many items are not be visible on cellphones.

ALL Background Check, at Lakeland and Corporate Screening are done by appointment only.

1.) Go to **VerifyStudents.com** register and pay ($67.25) for the background using code **lakelandbg** **print out the control form. DO NOT close the browser until after you print the form.** You have 30 days to use this form and then it expires. **You must bring the control form and your driver's license with you to be fingerprinted.**

2.) Go to **VerifyStudents.com** register and pay ($45) for the drug screen using code **lakelanddt** print out the drug screen form. A list of approved labs will appear on screen-*you may want to print this out also*. **You have 3 days to use this form and then it expires. DO NOT drink too much water as this will dilute the sample.**

* If your drug screen results are "positive," the lab will contact you and you must show proof of a valid prescription. If the results are "positive," for a disallowed drug you will have **one** additional opportunity to retest. (All costs are incurred by the student).
* If the retest is "positive" – student is no longer eligible for a health program and/or certificate.

If you have trouble registering or accessing your forms, please contact Corporate Screening 1.800.229.8606, choose option #4.

3.) After you have registered and paid for the background, please visit https://booklcc8.timetap.com/ to set up an appointment to have the prints run at Lakeland.
On the day of your appointment please call 1.440.525.7009 to let us know that you have arrived.

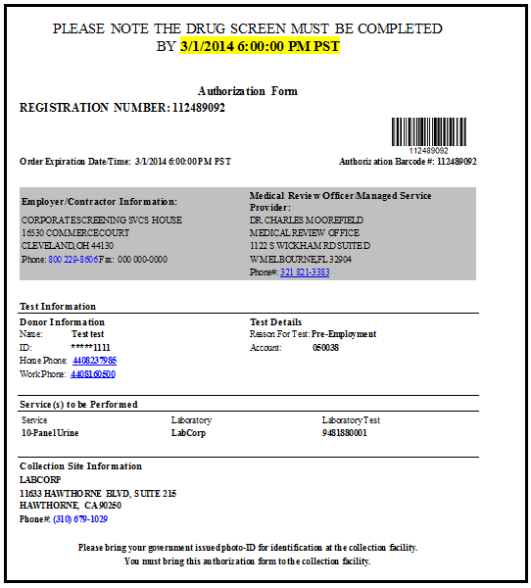
If you cannot come to Lakeland, for the background/prints, during the times available then contact Corporate Screening for an appoint at their office, 1.800.229.8606, choose option #4.

For questions:

Paula Pastor-Hinkel
Monday - Thursday 9 a.m. - 4 p.m.
Email: ppastorhinkel@lakelandcc.edu
Phone: 440.525.7009
Fax: 440.525.7860

Lakeland COMMUNITY COLLEGE

Please contact your program director for deadlines and start dates as to when to begin this process.



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:
CORPORATE SCREENING SVCS HOUSE
16530 COMMERCE COURT
CLEVELAND, OH 44130
Phone: 800 229-8606 Fax: 000 000-0000

Medical Review Officer/Managed Service Provider:
DR. CHARLES MOOREFIELD
MEDICAL REVIEW OFFICE
1122 S WICKHAM RD SUITE D
W MELBOURNE FL 32904
Phone#: 321 821-3383

Test Information

Donor Information
Name: Test test
ID: *****1111
Home Phone: 4408237986
Work Phone: 4408160800

Test Details
Reason For Test: Pre-Employment
Account: 050038

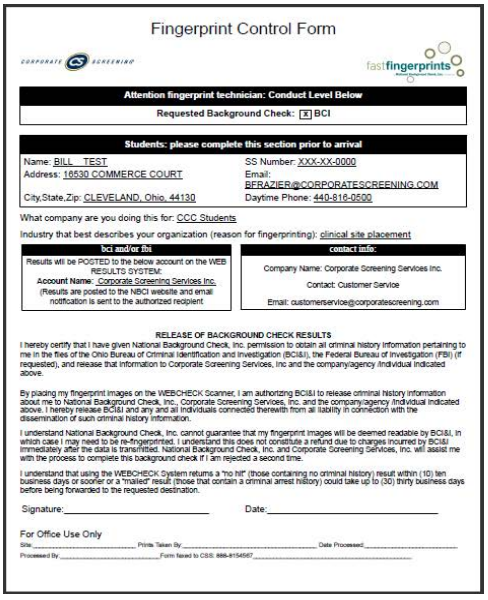
Service(s) to be Performed

Service	Laboratory	Laboratory Test
10-Panel Urine	LabCorp	9481880001

Collection Site Information
LABCORP
11633 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.

Sample Authorization Form



Fingerprint Control Form

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: RFRAZIER@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
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

contact info:
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_____

Sample Fingerprint Control Form

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 email the report to someone else.
- **PLEASE NOTE: If you have any technical questions, call Corporate Screening Customer Support at 1.800.229.8606, and choose option 4.**

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

If you have any questions, call 440.525.7009.

Last updated: July 15, 2021
PPH/JN

Lakeland COMMUNITY COLLEGE

LAKELAND COMMUNITY COLLEGE

EMT STUDENT HEALTH RECORD

— PLEASE PRINT ALL ENTRIES —

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	Lakeland ID#	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, attach a copy of the insurance card: _____		
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 EMT Director and the Dean of Science and Health and Clinical sites.

_____ _____

Student's Signature ***Date***

HEALTH EXAMINATION BY PHYSICIAN

Doctor: Please complete this form.

_____ _____ _____

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

REQUIRED					RECOMMENDED	
HEIGHT	WEIGHT	B/P PULSE	URINALYSIS Albumen _____ Sugar _____	BLOOD CBC Lab Report — **MUST** — be attached to this form.	VISION Right _____ Left _____ Corrected Right _____ Left _____	HEARING 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, Diphtheria & Pertussis) Vaccination Date: _____ **Flu Vaccination by injection** Date: _____

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

Rubeola (Measles) Titer Date: _____ **A copy of lab results must be attached**

Mumps Titer Date: _____ **A copy of lab results must be attached**

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

Hepatitis B, Aattach lab results for a positive titer Or sign a HepB declination/refusal form (this can be obtained at Lakeland Health Services).

2step TB test: date placed_____ **date read** _____ **date placed** _____ **date read** _____ **Results** _____
(It takes at least 9 days to complete a 2step TB skin test**)**
or
A QuantiFERON gold blood test: A copy of the lab results **MUST** be attached.

Recommended: (not required)

Polio Vaccine: Date _____, _____, _____ **or titer Date** _____ **A copy of lab results must be attached**

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

Physician's Name:

Address:

Phone:

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

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

Or fax 440-525-7860

1-12-2021