**FORM FILL-IN**

**Paramedic Program Application & Checklist**

**How to use this form-fill-in application:**

* + - **DO NOT HANDWRITE THIS APPLICATION. ALL APPLICATIONS MUST BE TYPED IN THE WORD FORMAT AS PROVIDED IN THE APPLICATION FORMAT BELOW.**
* Your computer must have Microsoft Office Version 2003™ or newer software installed for use, in order to fill in this application on your computer. (PC or MAC)
* Place your computer cursor over the grey area located in the Last Name section of the application form
* Begin typing, then you can “tab” through each remaining grey fill-in area and type the correct corresponding response
* For the “Yes” or “No” answers, simply place your cursor over the one you would like to select and click, it will place an “X” in the location you choose.
* When you are complete and you have **DOUBLE CHECKED** all your responses,
* Click on “File”
* Select “Save As”
* Save to either your “Desktop” or “My Documents” area of your computer
* Click on “File”
* Select “Print”
* PRINT THE COMPLETED APPLICATION FORM OUT ON A PRINTER (MAKE SURE IT IS CLEAR & READABLE)
* SIGN / DATE THE BOTTOM OF THE APPLICATION IN BLACK INK

**Have you attached the following to your completed application packet?**

* Completed program application, checked your responses and signed/dated the bottom of the application form
* Copy (front and back) of current signed Healthcare Provider (CPR) Provider card (AHA, ASHI, American Red Cross)
* Copy (front and back) of current **Arizona State EMCT certification card**
* Copy of current individual health insurance coverage (must be maintained throughout the program - must provide a copy of your current personal health insurance card)
* Copy of 24 Hour Hazardous Materials First Responder course completion certificate or ONLINE HAZWPR training.
* Proof of submittal application (receipt) or a copy of DPS Level I fingerprint clearance card and/or submittal to My Clinical Exchange Equivalent Background Check
* Letter (on agency letterhead) verifying at least two (2) calendar years of employment experience providing direct patient care for emergency medical patients **– (EXPERIENCED PROVIDERS APPLYING TO BEGIN SPRING COHORTS ONLY) (THIS DOES NOT APPLY TO STUDENTS THAT HAVE COMPLETED THE PRE-PARAMEDIC REQUIREMENTS)**
* Proof of your Reading, English and Math competencies

(Taken at the MCC Testing Services at Dobson & Southern Campus) <https://www.mesacc.edu/testing-services>

Documentation of Reading Score (must provide proof of one of the following items):

* Associate’s degree or higher
* ACCUPLACER Reading score of 92 or higher
* AIMS score of 720 or higher
* ACT Reading score of 22 or higher
* PSAT Composite score of 93 or higher
* SAT Composite score of 930 or higher
* \*ASSET Reading score of 47 or higher
* \*COMPASS Reading score of 91 or higher

(\* NOTE: MCCCD no longer accepts ASSET/COMPASS scores from other schools, unless posted in the SIS server prior to July 1, 2012.)

English101 with a grade of “C” or better or (must provide proof of one of the following items):

* Associate’s degree or higher
* ACCUPLACER Writing score of 75 or higher
* SENTENCE Skills score of 75 or higher
* WRITEPLACER score of 5 or higher
* \*ASSET Writing score of 41 or higher
* \*COMPASS Writing score of 70 or higher

(\* NOTE: MCCCD no longer accepts ASSET/COMPASS scores from other schools, unless posted in the SIS server prior to July 1, 2012.)

MAT112 with a grade of “C” or better or (must provide proof of one of the following items):

* Associate’s degree or higher
* ACCUPLACER Elementary Algebra score of 70 or higher
* ACCUPLACER Arithmetic score of 75 or higher (based upon current 2016 MCCCD requirements)
* COMPASS Pre-Algebra score of 46 or higher
* COMPASS Algebra score of 41 or higher
* \*ACCUPLACER Arithmetic score of 64 or higher (based upon MCCCD requirements in 2012
* \*ASSET NUM Skills score of 41 or higher

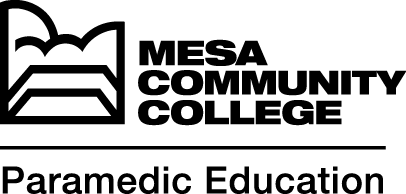
(\* NOTE: MCCCD no longer accepts ACCUPLACER/ASSET scores from other schools, unless posted in the SIS server prior to July 1, 2012.)

(the award of an Associate’s degree or higher may substitute this request or completion of both ENG101 and MAT112 with a grade of “C” or higher – must be verified with transcript submission)

* All unofficial transcripts from any colleges/universities attended previously
* Proof of (must provide clear legible copies):
  + TB testing or chest x-ray with a negative result within 6 months of the application **(annual requirement)**
  + Immunity to Rubella or Rubeola (MMR) **(series of 2 vaccinations or provide a titer)**
  + Immunity to Varicella **(vaccine or provide a titer)**
  + Proof of Hepatitis B immunity or evidence that you have declined the vaccination series **(series of 3 vaccinations or provide a titer)**
  + Proof of Tetanus (Tdap) **(booster received within last 10 years or provide a titer)**
  + Proof of annual Influenza/H1N1 vaccination **(seasonal typically available September-November)**
  + Proof of completion annual preventative physical examination **(completed within the last 12 months) (Physical Examination Verification & Medical History Forms are included in back of this packet)**  **(these must be performed and signed by a healthcare practitioner MD, DO, PA, NP)**

**SPECIAL NOTES:**

* **IF SUCCESSFULLY SELECTED FOR INCLUSION IN THE PARAMEDIC EDUCATION PROGRAM, YOU WILL NEED TO SUBMIT TO A RANDOM 12 PANEL URINE DRUG SCREEN WHICH INCLUDES A SCREEN FOR NICOTINE. DATE AND TIME WILL BE DETERMINED BY THE PROGRAM DIRECTOR AND IT WILL BE RANDOMIZED. FAILURE TO COMPLY WITH THIS REQUEST WILL RESULT IN YOUR REMOVAL FROM THE ELIGIBILITY LIST OR DISMISSAL FROM THE PROGRAM.**
* **THE URINE DRUG SCREEN WILL BE COMPLETED AFTER STUDENT SELECTION ONLY, IT IS NOT TO BE INCLUDED IN YOUR INTITIAL APPLICATION PACKET.**
* **ACCEPTED STUDENTS MAY ALSO BE REQUIRED TO PASS ADDITIONAL BACKGROUND CHECKS AND CLEARANCE AS REQURIED BY THE SPONSORING CLINICAL AND FIELD INTERNSHIP AGENCIES.**
* **FOLLOWING STUDENT SELECTION, ACCEPTED STUDENTS WILL BE REQUIRED TO PURCHASE SUBSCRIPTIONS TO THE “MY CLINICAL EXCHANGE” CLINICAL COMPLIANCE AND VERIFICATION SOFTWARE. THIS SUBSCRIPTION FEE IS $40.00 AND REQUIRES AN ADDITIONAL BACKGROUND CHECK CLEARANCE PROCESS AT AN ADDITIONAL FEE WHICH IS ASSESSED BY THE BACKGROUND CLEARANCE CHECK AGENCY. THIS ADDITIONAL FEE MAY BE UP TO $100.00 DEPENDING UPON THE LEVEL OF CLEARANCE REQUIRED.**

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**Prospective Paramedic Student Application Packet**

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| **Applicant (STUDENT) Information** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Full Name: | |  | | | | | | |  | | | | | | | | | |  | | | Date: | |  | | |
| *Last* | | | | | | | | | *First* | | | | | | | | | | *M.I.* | | | | | | | |
| Address: | |  | | | | | | | | | | | | | | | | |  | | | | | | | |
| *Street Address* | | | | | | | | | | | | | | | | | | | *Apartment/Unit #* | | | | | | | |
|  | |  | | | | | | | | | | | | | | | | |  | | | |  | | | |
| *City* | | | | | | | | | | | | | | | | | | | *State* | | | | *ZIP Code* | | | |
| Primary  Phone: | **(****)** | | | | | | | | | | | E-mail Address: | | | | |  | | | | | | | | | |
| Second Phone: | **(     )** | | | | | | | | | | | MCCCD Student ID# | | | | |  | | | | | | | | | |
| EMT program completed at: | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Date of program completion: | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| AZ EMCT certification number: | | | | | |  | | | | | | | | | | | Cert. Expiration: | | |  | | | | | | |
| Date of Birth: | | | | | |  | | | | | | | | | | | Social Security # | | |  | | | | | | |
| ***Attach copy of AZ EMCT certification card*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hazardous Materials First Responder program completed at: | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| Date of program completion: | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| ***Attach copy of HazMat course completion certificate*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Basic Life Support (CPR) Healthcare Provider card expiration: | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| ***Attach copy of signed CPR Healthcare Provider card (front and back)***  Annual Preventative Health Screening Examination (Physical Exam) completed on:     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Attach copy of signed Annual Physical Verification Form (must be signed by M.D., D.O., PA, NP)*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you a citizen of the United States? | | | | | | | | YES | | | NO | | If no, are you authorized to work in the U.S.? | | | | | | | | | | | | YES | NO |
| Do you have any physical or emotional disabilities that would keep you from performing the duties of a Paramedic? | | | | | | | | | | | | | | | | | | | | | | | | | YES | NO |
| If yes, explain: | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Have you ever been convicted of a felony? | | | | | | | |  | | | | | | | | | | | | | | | | | YES | NO |
| If yes, explain: | | |  | | | | | | | | | | | | | | | | | | | | | | | |
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| **Educational Background** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| High School / GED: | | |  | | | | | | | Address: | | | |  | | | | | | | | | | | | |
| From: |  | | To: |  | | | Did you graduate? | | | | | | | YES | | NO | | Degree: | | |  | | | | | |
| College: | |  | | | | | | | | Address: | | | |  | | | | | | | | | | | | |
| From: |  | | To: |  | | | Did you graduate? | | | | | | | YES | | NO | | Degree: | | |  | | | | | |
| Other: |  | | | | | | | | | Address: | | | |  | | | | | | | | | | | | |
| From: |  | | To: |  | | | Did you graduate? | | | | | | | YES | | NO | | Degree: | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **EMS / Medical Experience** | | | | | | | | | | | | | | | |
| Are you currently employed or have you been employed by an EMS, Hospital, Medical, Military or Public Safety Agency? | | | | | | | |  | | | | | | YES | NO |
| If yes, please fill out the information below: | | | | | |  | | | | | | | | | |
| Company: | |  | | | | | | | | Phone: | | **(     )** | | | |
| Address: | |  | | | | | | | | Supervisor: |  | | | | |
| Job Title: | |  | | | | | | | | | | | | | |
| Responsibilities: | | |  | | | | | | | | | | | | |
| From: |  | | | To: |  | | Reason for Leaving: | |  | | | | | | |
| ***For those individuals applying to the Spring semester (Track 2) program cohort for “Experienced Providers” or those applicants that have < 2 years verifiable experience as a practicing EMCT and HAVE NOT completed the REQUIRED Pre-Paramedic Courses. PLEASE READ BELOW:***  ***If you have not completed the REQUIRED Pre-Paramedic Courses, you must provide documentation verifying a MINIMUM of least two (2) years of verifiable field experience as a first responder EMCT. This letter should be written on agency letterhead and include dates of employment and a brief description of work duties. This letter MUST accompany this application.***  ***\*\*NOTE:***  ***THIS VERIFICATION LETTER IS ONLY REQUIRED WHEN APPLYING FOR THE SPRING SEMESTER (TRACK 2) “EXPERIENCED PROVIDER PROGRAM COHORT” OR FOR THOSE APPLICANTS THAT HAVE NOT COMPLETED THE PRE-PARAMEDIC REQUIRED COURSEWORK AND HAVE LESS THAN 2 YEARS VERIFIABLE EXPERIENCE AS A PRACTICING EMCT.***   |  | | --- | | **Applicant Short Answer Questions** |   Please take your time and reflect on your answers to the four (4) questions below. These will serve as follow-up questions, should you be invited to the oral panel interview phase of the selection process. It is very important that you give thoughtful and reflective answers to these questions and that you are prepared to discuss your answers further during the oral panel interview process. **(YOU SHOULD PAY VERY CLOSE ATTENTION TO GRAMMAR, PUNCTUATION AND SPELLING, EACH CANDIDATE SHOULD THOROUGHLY REVIEW THESE ANSWERS BEFORE SUBMITTAL)**   1. Briefly state your reasons for applying to the Paramedic Education Program at Mesa Community College.      1. Briefly summarize your patient care related experiences (if any) and explain why you want to become a Paramedic. (you may choose to include your past or current employment experience and/or any military or volunteer experiences).      1. Everyone has strengths and weaknesses as both workers and students. What would you identify as your strong points? What would you say are your areas that need improvement?      1. Give an example of a situation in which you functioned as a leader and how that affected you, or the outcome of the situation. (you may choose to reflect on school experiences, club experiences, sporting or athletic experiences, work or military experiences). | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Disclaimer and Signature** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| *NOTE:*  *All students accepted into the Mesa Community College Paramedic Education Program must either submit proof of and/or clear a comprehensive Department of Public Safety (DPS) background check to receive a Level 1 Fingerprint Clearance Card, (additional screening and clearance may be required by My Clinical Exchange) and a randomized comprehensive urine drug screen process including nicotine. Students with compromised backgrounds reflective of criminal activity or indications of a positive urine drug screen will be immediately dismissed from the program. Students will not be allowed to begin the clinical and field internship phases of the Paramedic Education Program until such time that both the background check clearances and negative urine drug screen are received and verified.*  *Students whom either electively withdraw or are dismissed due to academic, behavioral or other substandard performances following attendance at the first day of class, following the established withdrawal period; shall remain financially responsible to Mesa Community College for all course fees associated with the Paramedic Education Program and forfeit all applicable fees.*  *By signing below, I fully understand that any significant misstatements in or omissions from this application constitute cause for immediate dismissal from the Paramedic Education Program. I certify that all information I have provided on this application is true, accurate and complete to the best of my knowledge. I fully understand all requirements and financial obligations as stated within this application.*  *By signing below, I fully understand that I must be a currently certified EMCT in the State of Arizona and maintain a valid Arizona Department of Health Services Bureau of Trauma and EMS EMCT certification throughout the duration of the Paramedic Education Program. Any lapse in my Arizona State Certification will result in my immediate dismissal from the program and I will forfeit all tuition and fees paid.*  *By signing below, I hereby authorize and consent to the release of information regarding the Paramedic Education Program by Mesa Community College, if such a release of information is done in good faith and without malice and I hereby release from liability Mesa Community College and its representatives for doing so.* | | | | | | | | | | | | | | | |
| Signature: | |  | | | | | | | | | Date: | |  | | |

Please forward this completed application and all supporting documentation by mail or hand-delivered to:

**Mesa Community College**

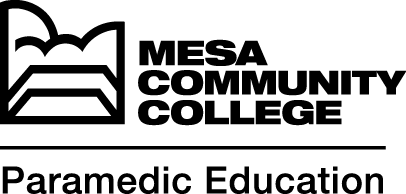
**Department of EMS/Fire Science**

**Paramedic Education Program**

**Attention: Sean P. Newton**

**145 North Centennial Way, 4th Floor**

**Mesa, AZ 85201**

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**PROGRAM APPLICANT**

**ANNUAL PHYSICAL VERIFICATION FORM**

**(this page for MD, DO, PA, NP use only)**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_\_\_\_\_\_Height: \_\_\_\_\_\_\_\_\_\_\_Weight: \_\_\_\_\_\_\_\_\_\_\_**

**Vital Signs: \*Pulse: \_\_\_\_\_\_\_\_\_\_\_ \*Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\*RR:\_\_\_\_\_\_\_\_\_\_\_ Skin : \_\_\_\_\_\_\_\_\_\_\_**

**(\* indicates a numerical assessment must be documented)**

**PHYSICAL EXAMINATION:**

**HEENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Vision: R:\_\_\_\_\_\_\_\_\_\_\_ L:\_\_\_\_\_\_\_\_\_\_\_ \*Corrected: R: \_\_\_\_\_\_\_\_\_\_\_ L: \_\_\_\_\_\_\_\_\_\_\_**

**(\* indicates a numerical assessment must be documented)**

**HEART:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LUNGS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ABDOMEN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EXTREMITIES/JOINTS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NEUROLOGIC/MENTAL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Based upon this physical examination, do you find any reason why this person cannot perform the duties of an Emergency Medical Services Provider (Paramedic)? YES: \_\_\_\_\_\_\_\_\_\_\_ NO: \_\_\_\_\_\_\_\_\_\_\_**

**If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Provider Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD, DO, PA, NP**

**Provider Signature (please sign): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Completed form should be returned directly to the patient or upon medical information release authorization, mailed directly to:**

**Mesa Community College**

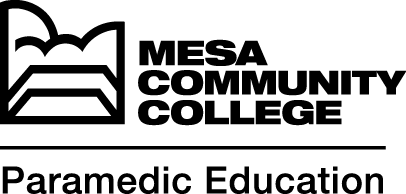
**Department of EMS/Fire Science**

**Paramedic Education Program**

**Attention: Occupational Program Director**

**145 North Centennial Way, 4th Floor**

**Mesa, AZ 85201**

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**PROGRAM APPLICANT / PATIENT MEDICAL HISTORY FORM**

**(this page to be completed by the program applicant & provided to the healthcare professional conducting the annual physical examination and completing the Annual Physical Verification Form)**

**Patient / Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 # of SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS:**  **(please check the YES or NO box to the right)** | **YES** | **NO** |
| **Vision or Hearing Problems (if YES, please explain)** |  |  |
| **Heart Problems (if YES, please explain)** |  |  |
| **Childhood Diseases (if YES, please explain)** |  |  |
| **Epilepsy, Diabetes, High Blood Pressure or Kidney Problems (if YES, please explain)** |  |  |
| **Bone/Joint Disease or Injury, Back Injury (if YES, please explain)** |  |  |
| **Serious Illness or Major Surgery, Hernias (if YES, please explain)** |  |  |
| **Mental Illness or Nervous Disorder (if YES, please explain)** |  |  |
| **Drug or Alcohol Problems (if YES, please explain)** |  |  |
| **Lung Disease (if YES, please explain)** |  |  |
| **Skin Problems or Diseases (if YES, please explain)** |  |  |

**By affixing my signature below, I hereby certify that this information is true and to the best of my knowledge.**

**Applicant Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**