



Daytime EMT – BASIC COURSE

Monday, Wednesday, and Friday 0900-1800
Starting Date – June 2nd, 2010

Course Site: Morris County Fire and Police Academy
500 West Hanover Avenue, Parsippany, NJ

Registration Information: 908-522-2323 press 3

FEES:

Volunteer Services – NJ Training Fund Eligible	Non-eligible Applicants
Free - Must Provide Certificate of Eligibility	\$700

NOTE: All fees include Textbooks and course materials

ABSOLUTELY NO REFUNDS After May 30th

Orientation: June 2nd at 0900hrs (All students are required to attend, class starts at 1030 hrs)

Prerequisite: You must have a current Healthcare Provider/Professional Level CPR card for entry. If you do not have a CPR card, call our office to arrange training in conjunction with the EMT – Basic course.

Make checks payable to – Atlantic Ambulance, and remit to:
Atlantic Ambulance
EMS Training Center
PO Box 220
Summit, NJ 07902
Fax: 908-522-5394

[WE WILL ACCEPT COMPLETE REGISTRATIONS ONLY!](#)

If your application is not complete, we will not reserve a spot in class for you until your application is complete.



Daytime EMT – BASIC COURSE

Monday, Wednesday, and Friday 0900-1800
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Please Print Clearly

NAME: _____ DAY PHONE: _____

ADDRESS: _____

CITY/ZIP: _____ OEMS# _____

AFFILIATION: _____ DATE OF BIRTH: ____/____/____

CPR EXPIRATION: ____/____/____ (Enclose Copy)

E-Mail Address: _____

For office use only

_____ Payment or COE

_____ Insurance Form or insurance card

_____ CPR Card

_____ Parental Permission (if under 18 y.o.)

_____ NJOEMS ID #

_____ Background check received

_____ Immunization records received

_____ Completed Confirmation sent



Atlantic Training Center
P.O. Box 220, Internal Box: MICU 256
Summit, NJ 07902-0220

A Division of:
Atlantic Ambulance Corporation
P.O. Box 1905
Morristown, NJ 07962-1905

Dear Student,

Thank you for choosing Atlantic Training Center for your EMT Basic course.

Attached is the registration form our office needs to be completed to process you for class. All the paperwork needs to be in the office before you will be confirmed for the class and a spot held for you.

The background check form and immunization records only need to be completed if you are going to do your clinical time at an Atlantic Health System facility. If you are going to a different hospital to complete your time, it is your responsibility to find out what they require. If you are under the age of eighteen, you do not need to complete the background check form.

If you do not have a current CPR card or are not certified in CPR, we will be holding a class to obtain certification. The date and time will be announced during the first day of the EMT Basic class. Please indicate on your registration form if you will need to participate in the CPR class we will be providing.

We have also included a flyer on how to register with New Jersey's Office of Emergency Services and obtain a six digit ID number from them. This will be your ID number for your EMT certification once you completed the class and pass the state exam.

Once you obtain the number you then need to access their site and register for the EMT Basic class that you are interested in taking with us. When you register on line, it will tell you that the class is full. This is not the case; we have it set this way on purpose. Once we have all your completed paperwork we will accept you on the LMS for the class.

To find the class on the NJOEMS site, you need to click on "course catalog" in the top line. This will bring you to another screen where you will have to click "catalog". Once you do this, you will see a search box. Type in 405 in the box and hit "search". This will bring you to the list of all the EMT Basic classes in the state. You will need to scroll down to find the class you would like to take with us. Be careful and make sure you are registering for the right class, as we have several listed. Follow the directions on site how to register for the class.

If at anytime you have any further questions or problems please contact our office at 908-522-2323 ext.3

Thank you again for choosing Atlantic Training Center for your training.

Sincerely,
Lori May, MICP, LPN
ALS/BLS Education Coordinator
Atlantic Training Center

T H E P A S S I O N T O L E A D

**New Jersey Department of Health and Senior Services
Office of Emergency Medical Services**

**EMT TRAINING FUND
CERTIFICATE OF ELIGIBILITY FOR AN EMT BASIC COURSE**

Name of Student: _____

Volunteer EMS Agency: _____

Address: _____ County: _____

City: _____ State: _____ Zip: _____

Course Sponsor: _____

Course Start Date: _____

The undersigned verifies that:

1. All of the information above is true and accurate.
2. The EMT listed above is a member or a prospective member of a volunteer ambulance, first aid or rescue squad and is eligible for reimbursement of EMT training expenses in accordance with N.J.A.C. 8:40A.
3. All monies paid for training will ONLY be made to the basic course sponsor.

Verified by:

Name of Principal Officer (Print): _____

Title: _____

Contact/Telephone Number: _____

Signature of Principal Officer: _____ Date: _____

NOTICE: It is a crime for any person knowingly or willfully to provide false information on this application, or make deliberately misleading statements regarding the eligibility of applicants [N.J.S.A. 2C:21-4(s)].

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TRAINING CENTER

2007 EMT-Basic Course Training Insurance Form

Registrant's Full Name

Registrant's Full Name

Note: Please print – additional registrants may be listed on reverse side of form.

To the fullest extent permitted by law, the municipality, or agency requesting training for this individual agrees to defend, indemnify and hold harmless the County of Morris, the Morris County Fire Fighters and Police Training Academy, and all employees, servants and agents ("the county") from any liability, claims, civil actions and expenses, (including reasonable attorney's fees), arising out of the training or instruction to be provided at the academy. Said agreement shall apply, regardless of the allegations made against the County by the student, this organization or a third party, and even if the claim, etc. involves an allegation of improper, negligent, or inadequate instruction, training or curriculum.

Authorized Official's Certification: I hereby certify that all personnel from this department enrolled in the above course are covered by Workmen's Compensation and Liability Insurance or are otherwise adequately insured.

Signature

Department / Agency Name

Date

Mailing address:

Street

City, State, Zip

Department / Agency Phone #: _____

Note: If no affiliation, please attach a copy of your insurance card and sign as the authorized official.

REQUEST FOR BACKGROUND INFORMATION

Atlantic Health Systems – Atlantic Training Center –EMT Students

Account #25

NOTICE TO APPLICANTS REGARDING CONSUMER REPORTS AND INVESTIGATION CONSUMER REPORTS

This is to inform you that a consumer report and/or an investigative consumer report may be obtained as part of our procedure for processing your application. A consumer report means any written, oral or other communication by a consumer reporting agency bearing on your credit worthiness, credit standing, credit capacity, general reputation, personal characteristics or mode of living. An investigative consumer report means any information on your character, general reputation, personal characteristics or mode of living obtained through personal interviews with neighbors, friends or associates. Within a reasonable time, you may request in writing a disclosure of the nature and scope of the investigative credit report as well as a written summary of your rights under section 1681g(c) of the Fair Credit Reporting Act. Before taking any adverse action based in whole or in part on a consumer report and/or an investigative consumer report, Atlantic Health System will provide you with a copy of the report, the name, address and telephone number of the reporting agency that furnished the report and a description of your rights under the Fair Credit Reporting Act.

I hereby authorize Atlantic Health System and its affiliated entities to obtain consumer reports and/or investigative consumer reports in connection with my application for employment and/or employment with Atlantic Health Systems or my participation in a clinical affiliation or other educational program at an Atlantic Health System facility. I authorize all former employers, listed references, law enforcement agencies and courts to release to Atlantic Health System and/or their representatives information pertaining to me. By providing this authorization, I hereby release Atlantic Health System, its affiliated entities, employees and agents from all liability for requesting and/or acting based on any such report and release all other parties from liability for furnishing such information.

Student Signature

Date

(Please print clearly)			Male or Female
First Name	Middle Name	Last Name	Other Name(s) used
Date of birth		Social Security Number	
Student's mailing address			
Student's previous mailing address			

OFFICE USE ONLY: Fax Request to (908) 879-8675

Your IABB Inc. Account Manager – Janet Cillo Telephone (908) 879-4816 E-mail janetcillo@tabb.net

- * Please indicate the report requested with an (X)
- * () Database Search and Criminal Record Search at all addresses
- * () Driving Record (Enter License Number and State Issued) _____
- * **REPORT REQUESTED BY:** Lori May, ALS/BLS Education Coordinator **TELEPHONE:** (908) 522-2895
- * **FAX RESULTS TO:** Jeff Carrie (973) 290-0052 * **FAX ADVERSE RECORDS TO:** A. Robinson (973) 660-9276

RESULTS:

(Do not write in space below)

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TRAINING CENTER

LMS INFORMATION SHEET

All students must obtain a Student ID in the Learning Management System (LMS)

Go to the LMS Website at www.njoemscert.com



Click on “I need to create an account: (red arrow)

On the “Create User Account” page, read the directions and fill in the information.

Submit the completed form. If you are having problems creating an account, contact User Support at 1-888-463-0252.

Once you obtain your “State ID” please record it on the course application.

ATLANTIC HEALTH
Immunization/Training Record
For Non-Atlantic Health
Student, Agency, or Contract Personnel

Name: _____ Social Security #: _____ DOB: _____

Address: _____

Name of School/Agency: _____

Supervisor (if applicable): _____

IMMUNIZATION	YES/DATES	NO
<p><u>Hepatitis B:</u> (Must have one of the following)</p> <p>A. Proof of having all three doses of the Hepatitis B Vaccine.</p> <p>B. Documentation of a positive Hepatitis Surface Antibody (HBsAb).</p> <p>C. Vaccine Waiver Form: (see attached)</p>		
<p><u>Rubeola (Measles):</u> if born after 1956 (Must have the following)</p> <p>A. Measles Titer: Immune: _____ Non-immune: _____</p>		
<p><u>Rubella (German Measles):</u> applies to all</p> <p>A. Rubella Titer: Immune: _____ Non-immune: _____</p>		
<p><u>Mumps:</u> Must have one of the following</p> <p>A. Proof of immunization with live mumps (or MMR) vaccine after his/her first birthday.</p> <p>B. Documentation of a case of physician-diagnosed mumps.</p> <p>C. Mumps Titer: Immune: _____ Non-immune: _____</p>		

IMMUNIZATION	YES/DATES	NO
<p><u>Varicella Titer:</u> (Must have one of the following)</p> <p>A. Proof of two doses of varicella vaccine, 4-8 weeks apart.</p> <p>B. Documentation of a case of physician-diagnosed varicella.</p> <p>C. Varicella Titer: Immune: _____ Non-immune: _____</p>		
<p><u>Tuberculosis Skin Testing (TST)*:</u></p> <p>A. Adequate two-step TST (2 Mantoux tests given within 1-3 weeks of each other) within the past 12 months, OR</p> <p>B. Single TST if one documented negative TST within the past 12 month, OR</p> <p>C. Adequate two-step TST followed by annual testing.</p> <p>If positive TST :</p> <p>D. Documentation of test result and negative chest X-ray.</p> <p>E. Documentation that individual does not have active tuberculosis infection.</p> <p>F. If latent tuberculosis infection, documentation of adequate treatment if individual was treated.</p> <p>If evaluated with blood assay for <i>Mycobacterium tuberculosis</i> (BAMT), those results should be submitted instead of TST.</p>		
<p><u>TRAINING:</u> <u>Hazard Communication/Right to Know:</u></p> <p>A. Awareness of biological hazards in health care institutions.</p>		
<p><u>INFECTION CONTROL</u></p> <p>A. Understands epidemiology and symptoms of bloodborne (Hepatitis B and C and HIV) diseases, tuberculosis, and influenza.</p> <p>B. Understands modes of transmission of bloodborne pathogens, tuberculosis, and influenza and similar infections.</p> <p>C. Understands isolation precautions and the appropriate use of personal protective equipment.</p>		

Occupational Injuries and Illnesses: All schools or agencies must have a prior arrangement with their students/personnel of what to do in the event of an occupational injury or illnesses, including bloodborne pathogen exposures.

Contagious Diseases: This individual completing this form is free from contagious disease.
Yes _____ No _____

=====

Signature of student/agency/contract personnel

Date

Signature of health practitioner (REQUIRED)

Name and Title of Atlantic Health employees who reviewed record

Signature of Atlantic Health employee who reviewed record

Date

