ATLANTIC
TRAINING CENTER

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,

We are pleased that you have chosen Atlantic Training Center for your EMT Basic course and we thank you very much for that decision.

Attached is the registration form our office needs completed to process you for class. Also attached is a flyer on how to obtain an ID number from the State of New Jersey. Please follow the directions to obtain your number. When you register on the website, please include an email address. This is the only way the state will confirm that you are registered for a test and they way they will get information out to you.

Once you have your number, you need to enter the site and register for the class on-line with NJOEMS.

To do this you will need to log onto: www.njoemscert.com. Once you have logged on you will need to then click on 'catalog'. In the search box please enter the code 405 and click search.

This will bring you to all the EMT Basic classes given in the state. You will need to scroll to find our class and follow the directions from there to register for the class.

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

Again thank you for choosing Atlantic Training Center for your training.

Sincerely,
Lori May
ALS/BLS Education Coordinator
Atlantic Training Center
908-522-2323
www.atlanticambulance.org

Daytime EMT – BASIC COURSE

Monday, Wednesday, Friday 0900-1800
Starting Date – June 1st 2009

Course Site: Morris County Fire and Police Academy
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 28th 2009

Orientation: **June 1st** 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, Friday 0900-1800
Starting Date – June 1st 2009

____

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

____________Completed Confirmation sent

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)].

EMS-80
AUG 03

ATLANTIC
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 TABB 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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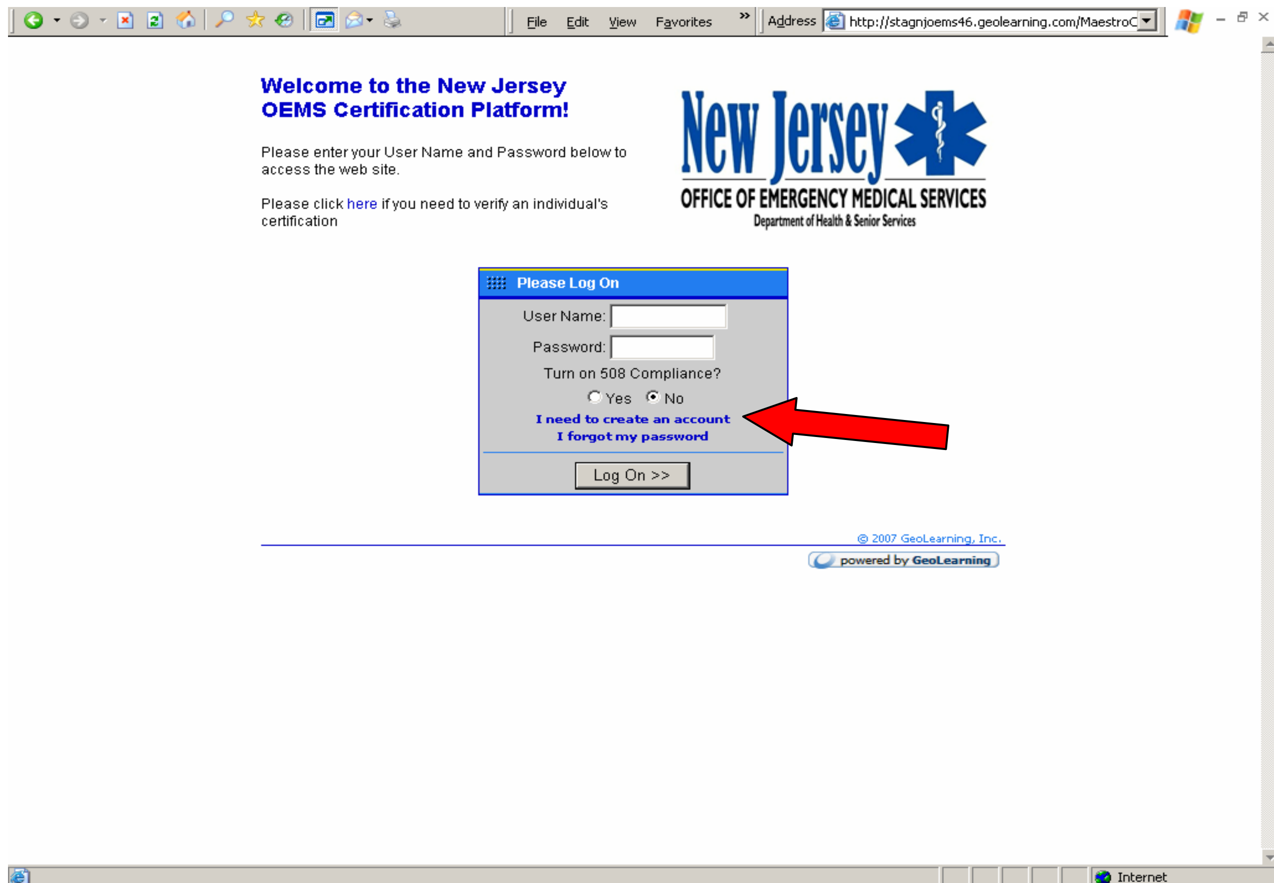
LMS INFORMATION SHEET

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
Hepatitis B: (Must have one of the following) A. Proof of having all three doses of the Hepatitis B Vaccine. B. Documentation of a positive Hepatitis Surface Antibody (HBsAb). C. Vaccine Waiver Form: (see attached)		
Rubeola (Measles): if born after 1956 (Must have the following) A. Measles Titer: Immune: _______ Non-immune: ______		
Rubella (German Measles): applies to all A. Rubella Titer: Immune: _____ Non-immune: _______		
Mumps: Must have one of the following A. Proof of immunization with live mumps (or MMR) vaccine after his/her first birthday. B. Documentation of a case of physician-diagnosed mumps. C. Mumps Titer: Immune: _____ Non-immune: _____		

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

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 ______

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____ __________
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

ATLANTIC HEALTH SYSTEM

Hepatitis B Vaccination Declination

I, ____, understand that due to my
print
occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. However, I have declined to be vaccinated for hepatitis B. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

____________________ ____
Date Signature