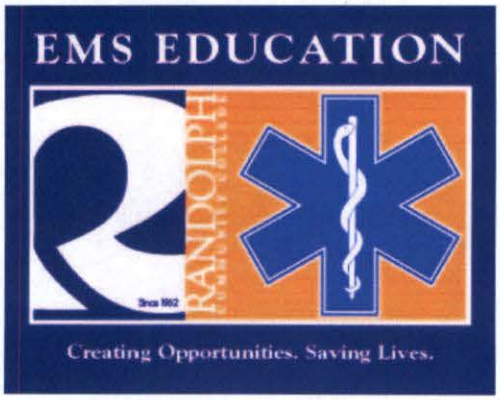

Date: _____

To Applicant: _____

Thank you for your interest in the Advance Emergency Medical Technician or the Paramedic course here at Randolph Community College. Your required documentation prior to being able to register for the course are listed below:

_____ In date/valid NC DMV Driver's License

_____ Official copies of high school transcript or diploma/ GED

_____ Current NC EMT Certification must be complete by June 30, 2023 (the start of pharmacology)

_____ Current AHA Health Care Provider BLS certification

_____ Reading comprehension, English language skills and Mathematical skills on the post-secondary level

- Placement into college level English and Math courses are required. (See attached documents for further details) *********** Placement score must be within the last 3 years ***************

_____ Authorization for submission of Criminal Background Check and Drug Screen Test

_____ Completed and signed Scholarship Information Packet (if desired)

_____ Completed and signed physical from a physician with a vaccination record included. (See attached document for required immunizations).

***********Paramedic Students***********

Anatomy and Physiology is required prior to the completion of the paramedic course. Randolph Community College does offer this course online for EMS providers as **EMS 3163**. Others that may be accepted include BIO 163, BIO 165 and 166, or BIO 168 and 169.

Please submit these items to the Continuing Education Office. If you have any questions, please contact 336-633-0268

Randolph Community College EMS Advanced Life Support Programs

Admission Requirements

(Student must provide official documentation **PRIOR** to admission to the course)

- In Date/Valid NC DMV Driver's License
- Official copies of high school transcript and/or GED test scores and **all** college transcripts
- Current NC EMT Certification
- Current AHA Health Care Provider BLS Certification
- Assessment for Reading, Writing and Math **(Those with post-secondary education will be required to provide official transcripts in order to opt out of Assessment Tests. Degree must have been obtained within the last 3 years). Visit the Student Success section on the website or call 336-633-0200.** Students who do not meet the cut scores on placement assessment(s) must complete and pass Developmental Studies courses with a grade of "C" or better prior to registering for the course.
- Authorization for submission of Criminal Background Check and Drug Screen Test
- Complete Immunization Records to include:
    - Tetanus Booster within 10 years (TDAP)
    - Current documentation of 2 step PPD Skin Test or if positive history, a current QPPD (Tuberculosis Questionnaire) and chest x-ray within 1 year, or a Quantiferon blood draw.
    - MMR (measles, mumps and rubella) 2 documented vaccinations or positive titers for measles, mumps and rubella
    - Hepatitis B vaccine (3 dose vaccination)
    - Varicella-Positive serum titer or 2 documented Varivax Vaccines
    - Seasonal Flu vaccination
    - COVID-19 Vaccine (2 dose of either brand)
        - **Randolph Community College does not require this vaccine for class attendance, but some hospital clinical sites may. Currently we have at least one site who does not require it, so it is listed as optional for students.
- RCC's Health History Form and Immunization Policy which is included in this packet.

Please see a more detailed list of the required immunizations later in this document

Class Location

- All classes and labs will be conducted at the Asheboro Campus of RCC in the Robert S. Shackleford Allied Health Building (RSS) classrooms 105 and 108 unless stated otherwise. Computer labs will be used for exams, the Emergency Services Training Center may be used on occasion, and off-campus locations may be utilized for specific purposes. Notification will be given for any of those occasions.
- Clinical locations will vary throughout the area depending upon availability and student need.

Class Times

- Class during the first section will run from 09:00 (9am) to 16:00 (4pm) on Tuesdays and Thursdays, with labs about once per month on Fridays from 09:00 (9am) to 13:00 (1pm). During the second section of the course class will only meet on Tuesdays from 09:00 (9am) to 16:00 (4pm). The schedule will vary during final testing, see the schedule for specifics.
- Clinical times will vary according to site availability and student need. Typical shift schedules are from 07:00 (7am) to 19:00 (7pm) but will be location-specific.

Certified Background Check and Drug Screen Instructions:

This must be completed within 30 days of the course start date.

The information to obtain your certified background check and drug screen will be given out on the first day or night of class.

Clinical Sites utilize the following services for onboarding. Fees are separate from registration:

Provider:	**Fee:**		**Service:**
Castlebranch	$100		Drug Screening and Background Checks
myClinical Exchange	$40	(six months)	Immunizations, Fit Testing, Hospital Site training videos

Course Charges for Part I Paramedic

Registration Part I Paramedic	$180.00 (if affiliated this fee is waived)
Student ID:	$0.50/year
Liability Insurance	$16.00/ policy year must be renewed
Accident Insurance	$0.55/ policy year must be renewed
AHA Fee	$37.00
Supply Fee	$150
Resource Fee (Platinum Planner/EMS Testing)	$189.00
Total Due at Registration	$572.60 (less 180.00 if tuition exempt = $392.60)

Books	~$ 900.00 (this is an estimate)
Uniforms	~$ 200.00 (this is an estimate)
	~$1200.00 (this is an estimate)

Total cost of Part I: ~$1,772.60 or $1,592.60 (if tuition exempt)

Course Charges for Paramedic (Part II)

Registration Part II	$180.00 (if affiliated this fee is waived)
Liability Insurance	$16.00/ policy year
Accident Insurance	$0.55/policy year
Total due at Registration	$196.55(less 180.00 if tuition exempt = $16.55)

Other fees during the course:

Book fees listed above will include the following textbooks:

- Nancy Caroline's Emergency Care in the Streets 9th Edition:

  Volume 1 & 2: ISBN: 9781284256741 (List Price $366.95)

- Pharmacology for the Prehospital Professional 2nd Edition by Jeffrey S. Guy

  ISBN: 9781284041460 (List Price $108.95)

- Arrhythmia Recognition: the Art of Interpretation, 2nd Edition by Daniel J. Garcia and Tomas B Garcia

  ISBN: 97812842114321 (List Price $136.95)

- 12-Lead ECG: The Art of Interpretation, 2nd Edition by Tomas B Garcia

  ISBN: 9780763773519 (List Price $143.95)

- AHA 2020 ACLS Provider Manual

  ISBN: 978-1-61669-772-3 (List Price $45.50)

eBook: ISBN: 978-1-61669-797-6 (List Price $39.50)

- AHA 2020 PALS Provider Manual

  ISBN: 978-1-61669-785-3 (List Price $54.00)

  eBook: ISBN: 978-1-61669-804-1 (List Price $48.00)

Advanced Emergency Medical Technician (AEMT) Course Fees:

Registration Fee	$180.00 (if affiliated this fee is waived)
Student ID	$0.50
Liability Insurance	$16.00
Accident Insurance	$0.55
Resource Fee (Platinum Planner/EMS Testing)	$130.00
Supply Fee	$80.00
AHA Fee	$37.00
Total due at Registration	**$444.05 (less $180 if registration fee waived $264.05)**

Additional Fees:

Certified Background (with drug screen) $ 100.00 **(This must be completed at least 30 days prior to the start of clinical)**

Books	~$ 400.00 (this is an estimate)
Uniforms	~$ 200.00 (this is an estimate)
	~$700.00 (this is an estimate)

Total cost estimated cost of course: ~$1,144.05 or $944.05 (if tuition exempt)

Required Textbook: Advanced Emergency Care and Transportation of the Sick and Injured 3rd edition ISBN: 9781284136562

Clinical/Field Internships

Students must have the ability to remain flexible and have reliable transportation. The Clinical schedule varies from 6am to 11pm Monday – Sunday and will involve travel.

Reading, Writing and Math Assessments

All students must pass a reading, writing and math assessment or have records that indicate a proficiency in these subjects (within the past 3 years). The Assessment Verification form is included in this packet.

Uniform/Dress Code Requirements

Emergency Medical Services is a part of Public Safety and as such is a uniformed service. Students in the RCC EMS Paramedic program will be required to attend class and clinical internships wearing their approved uniform. The uniform will consist of the following:

o RCC EMS uniform shirt	$18.00
o RCC EMS uniform t-shirt	$9.00
o EMS style Cargo Pants	~35.00 and up
o Black leather or nylon duty belt	~15.00
o Black EMS style uniform shoes or boots	~50.00 and up
o Black socks	~5.00
o Wristwatch or device that measures seconds (pulse)	~5.00 and up
o All weather jacket (black or navy blue)	~50.00
o Reflective traffic vest	~15.00
Total Uniform Cost	~205.00

****** All prices for items from outside vendors such as books, uniforms etc. are subject to change.**

Randolph Community College

Preliminary Application for Admission to the AEMT/Paramedic Course

Academic Year 2023-2024

Personal Information (PLEASE PRINT)

_____ _____ _____

Last Name First Name Middle Name

____/____/_____ ____-___-_____ _____

Date of Birth Social Security Number RCC Student ID (if known)

Address_____

City_____ State_____ Zip_____

Phone (____)_____ Cell (____)_____

Email Address _____

Applications can be returned to Randolph Community College in the CEIC Building. Please mark "EMS Paramedic/AEMT Program Attention: David Barr"

****Students will not be registered until they fill out the Randolph Community College Continuing Education Application and pay all associated tuition/fees due upon registration.**

Randolph Community College Clinical Requirements | 2023

Misc.(not until class start)	Date
Criminal Background Check	
Urine Drug Screen	

Immunizations	Date
Flu (seasonal Oct-Mar)	
MMR ▪ 1st ▪ 2nd ▪ titer	Date
Varicella (Chickenpox) ▪ 1st ▪ 2nd ▪ titer	Date
Tetanus/ Diptheria (Tdap) (within the last 10 years)	Date

Tuberculosis ▪ PPD #1/Quantiferon	Date
Tuberculosis • PPD #2 /Quantiferon	Date
Hepatitus B Vaccine (HBV) ▪ 1st ▪ 2nd ▪ 3rd ▪ Titer	Date
COVID-19 Vaccine **optional** ▪ 1st ▪ 2nd	Date
Seasonal Flu • Latest dose received	Date

*Varicella history of the disease is no longer acceptable. Medical students are required to have a documented serology. If serology result is negative, students must also provide documentation of two (2) doses of Varicella vaccine.

*Influenza is required from October 1st through March 31st

*Tuberculosis skin test done within the last 12 months. Must have a minimum of 7 days between 1st TB skin test administered and the 2nd. If you have tested positive for TB in the past, you must provide a copy of TB skin test with mm measurement at the time of testing positive for TB or positive IGRA (Quantiferon) report. Chest x-ray with report must be done within 60 days of start date and any treatment documentation.

Student:

Program:

Randolph Community College

Student Medical Form for Programs that Require Health Forms

Randolph Community College
Health Science Division
Robert S. Shackleford Allied Health Center
606 Industrial Park Avenue
Asheboro, NC 27205

For questions, please contact Angela Bare, Administrative Assistant for Health Sciences:
336-633-0264
arbare@randolph.edu.

Welcome to Randolph Community College! We are glad you have chosen to complete your education here in one of our Health Science programs.

The Student Medical Form is required by clinical agencies for students to be able to participate in clinical experiences. Each program will indicate to students when these forms are to be completed. It is expected that the student will submit an honest and accurate record. Omissions, whether intentional or not, may impact the acceptance and/or approval of your admission.

Once the Medical Form is completed and submitted to the program, **the student is responsible for notifying the program in writing of ANY changes to the Medical Form within 5 business days of the change (i.e. injury, pregnancy or other condition that could affect participation in clinical). Such changes may require an additional attestation by a physician or health care provider of your ability to participate in clinical.** Failure to follow these procedures may lead to the student's inability to participate in clinical.

Revised October 2021

Students should follow these guidelines when completing the Student Medical Form:

- Each program will notify the student when this form is due. Failure to submit the information by the due date may result in the inability to progress in the program or dismissal from the program.
- Refusal to obtain required immunizations (or titers) may result in the inability to progress or dismissal from the program.
- This form should be completed no more than six (6) months (or longer if indicated) before the student begins the clinical program by the physician, physician's assistant or nurse practitioner familiar with the student and his/her medical history.
    - If you are being treated for any medical or mental condition that requires continued treatment or monitoring, you MUST have the physician who is treating you fully complete the Physical Examination and the Required Medical Assessment section on the form.
    - If you are not being treated currently for a medical condition, you may have any physician complete the medical part of the form.
- Be sure that the physician, physician's assistant, or nurse practitioner completes the immunization record and physical examination forms **and** he/she **SIGNS (not a signature stamp)** and dates the form. The form also requires an official office stamp in addition to the signature and date.
- The Immunization Record is extremely important. To avoid problems completing this information, read the Guidelines for Completing Immunization Record (see page 2). If you have any questions, please refer them to the Clinical Coordinator and/or Department Head for the program.
- If the student is not continuously enrolled (i.e. is not enrolled for a consecutive Spring and Fall semester), then the student must obtain a new medical form for the program.

Instructions for Completing the Student Medical Form:

1. Make an appointment with your primary care provider, or health care provider.
2. Student completes Form A: Personal Information
3. Form B: Medical Form Review Attestation by Student.
4. Primary care provider, or health care provider completes Form C: Immunization Record and Form D: Physical Examination
5. Ensure that the health care provider signs and the clinic stamp is noted on the form.

When the Medical Form is complete, the ***student should make a copy for his/her personal records.*** Please **SIGN** this form which is to be submitted with the original medical form to the program. Please contact the Clinical Coordinator and/or Department Head and/or Administrative Assistant for Health Science Programs for the program in which you are applying, if you have any questions.

I am submitting this completed Medical Form and attest that it is true and complete to the best of my knowledge. I understand that if anything on this form changes while I am a student in a health program, I must notify the program director in writing within 5 business days of the change.

I understand the Randolph Community College's Health Programs will share health and immunization information with appropriate clinical agencies for onboarding processes or in the event of a medical emergency.

Health and immunization requirements are based upon contractual agreements between Randolph Community College and clinical agencies that provide clinical learning environments for students. Students must be in compliance with all health/immunization requirements to be eligible to participate in clinical opportunities at each facilities discretion. If a student does not meet and maintain health/immunization requirements for a specific agency, they are not eligible to participate in clinical in that facility. If the student cannot satisfactorily meet clinical requirements required of the associated program, the student will not be allowed to progress in the program and will be dismissed from the program.

Student Name (Print)	Student Signature	Date

FORM A:
Personal Information—To Be Completed By Student (Please print in black ink)

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN LAST 4 DIGITS SOCIAL SECURITY NUMBER

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

DATE OF BIRTH (mo/day/yr)_____ GENDER ☐ M ☐ F MARITAL STATUS __S __M __ OTHER

EMAIL_____

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) – if no insurance, please write in N/A.

NAME OF POLICY HOLDER EMPLOYER

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP (Should be Next of Kin)

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

Is it Ok to contact above person in the event of an emergency? YES _____ NO _____

Please list any medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

☐ Not currently taking any medication, prescribed or over the counter.

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN DATE OF BIRTH(MO/DA/YR)

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet). Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)			

FORM B:
Medical Form Review Attestation To Be Completed By The Student

LAST NAME (print)	FIRST NAME	MIDDLE/MAIDEN	DATE OF BIRTH(MO/DA/YR)

STATEMENT BY STUDENT (OR PARENT /GUARDIAN, IF STUDENT UNDER AGE 18):

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

Signature of Student **Date**

Signature of Parent/Guardian, if student under age 18 **Date**

FORM C:
GUIDELINES FOR COMPLETING IMMUNIZATION RECORD AND TB SCREENING

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN DATE OF BIRTH(MO/DA/YR)

IMPORTANT – The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit. Please review information noted in each section prior to entering information in sections A, B, and C.

All written information must be supported by documents (NCIR Registry, Titer Result from Laboratory Company, Employee Health Record, Pediatrician Office, etc.).

Acceptable Records of Your Immunizations May be Obtained from Any of the Following: (Be certain that your name, date of birth, and ID Number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and year. **Keep a copy for your records.**)

- High School/Previous College/University Records – These may contain some, but not all of your immunization information. Contact Student Services for help if needed. **Your immunization records do not transfer automatically. You must request a copy.**
- Personal Shot Records – Must be verified by a doctor's signature or by a clinic or health department stamp, including a printout from any Immunizations Registry.
- Military Records or WHO (World Health Organization Documents)
- Employee Health records are not sufficient, unless you received the required immunization from the facility and it is appropriately documented on the submitted document.

Item to Complete:	How to Complete It:	Completed and Documented:
MMR	2 vaccines or positive titer*	□
Varicella (Chicken Pox)	2 vaccines or positive titer* (history of the disease is **NOT** sufficient proof of immunity)	□
Hepatitis B	3 vaccines or positive titer*, or 2 dose series of Hep-B	□
TB Skin Test **	Complete: 1) the Baseline Individual TB Risk Assessment Form (https://www.cdc.gov/tb/topic/infectioncontrol/pdf/healthCareSettings-assessment.pdf) 2) a two-step PPD (2nd PPD administered 1-3 weeks after 1st PPD is read) within the last 12 months OR QuantiFERON®–TB Gold In-Tube test (QFT-GIT) or T-SPOT®.TB test (T-Spot)	□
Tdap	Within 10 years (TD is **NOT** acceptable; must include pertussis)	□
Flu Shot	Given only during flu season; nothing to upload until flu vaccine for most current flu season	□
Covid	1 vaccine or 2 vaccine based on manufacturer	□

*If a titer is submitted, a laboratory report must be attached. The healthcare provider should document positive or negative immunity.

**If a student has had a positive TB skin test in the past, such as due to TB exposure/infection or receiving the BCG vaccine, a chest x-ray will be required along with the Baseline Individual TB Risk Assessment and TB symptom evaluation. (Note: If a PPD is positive, chest X-ray should be negative for TB disease; X-ray should be no older than 1 year and individual asymptomatic for TB).

FORM C: IMMUNIZATION RECORD AND TB SCREENING, To Be Completed By Health Care Provider

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN DATE OF BIRTH(MO/DA/YR)

	Documentation of Compliance
TUBERCULOSIS **All Students must complete one of the following screening tests** ▪ Screening with a 2-Step TST within 12 months of starting the program, must be administered 1-3 weeks apart with one 60 days within start of program. ▪ 2 consecutive annual tests administered 10 to 12 months apart, with the most recent administered within the past 12 months. ▪ QuantiFERON Gold blood test (lab report required) within the last 12 months. If positive results, submit: ▪ A clear chest x-ray (report required) within the last year, AND proof of past positive testing. ▪ A Symptom Free TB questionnaire from the last 12 months (clinic site specific).	**2-Step Test** 1st TST: Date Read_____ Result _____ mm of induration 2nd TST: Date Read_____ Results _____ mm of induration **OR** 2 Consecutive Tests _____ Date _____ Date **OR** TB Blood Test Date (must attach lab report) _____ **AND/OR** Documentation by provider of chest x-ray attached for past positive PPD or blood test.
Measles, Mumps and Rubella (MMR) Two MMR Vaccines OR Positive MMR Titer (must include all components, and lab report must be submitted.	MMR Vaccine #1 _____ Date MMR Vaccine #2_____Date **OR** MMR Titer Lab attached (must include date drawn, numeric result and range of immunity. **Please Circle Immunity Result:** Positive or Negative
Varicella Two Varicella Vaccines OR Positive Varicella Titer (must include all components, and lab report must be submitted	Varicella Vaccine #1 _____ Date Varicella Vaccine #2_____Date **OR** Varicella Titer Lab attached (must include date drawn, numeric result and range of immunity. **Please Circle Immunity Result:** Positive or Negative

Healthcare Provider Clinic Stamp Required:

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN DATE OF BIRTH(MO/DA/YR)

Hepatitis B Three Hepatitis B Vaccines OR Positive Varicella Titer (must include all components, and lab report must be submitted.	Hepatitis B Vaccine #1 _____ Date Hepatitis B Vaccine #2_____Date Hepatitis B Vaccine #3_____Date **OR** Hepatitis B Titer Lab attached (must include date drawn, numeric result and range of immunity. **Please Circle Immunity Result:** Positive or Negative
Tdap One Adult Tdap within the last 10 years	Tdap Vaccine #1_____Date
COVID Must identify manufacturer, which identifies number of doses required	Manufacturer of vaccination _____ Vaccine #1 _____Date **OR** Vaccine #1 _____Date Vaccine #2 _____Date
Influenza (Seasonal) Required annually, in the fall of the year, generally around October 1. Due date to be announced annually and not required prior to admission.	

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

Office Address **City** **State** **Zip Code**

Healthcare Provider Clinic Stamp Required:

FORM D:
PHYSICAL EXAMINATION—To Be Completed By Health Care Provider (Please print in black ink)

A physical examination is required. It must be completed in black ink and signed by a health care provider.

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN DATE OF BIRTH (MO/DA/YR)

Height _____ Weight_____ TPR _____/_____/_____ BP _____/_____

ALL SECTIONS REQUIRED:	ALL SECTIONS REQUIRED:
Vision: Corrected Right 20/ _____ Left 20/ _____	Hearing: (gross) Right _____ Left _____
Uncorrected Right 20/ _____ Left 20/ _____	Whisper Right _____ Left _____
Color Vision _____	

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Genitourinary			
7. Musculoskeletal			
8. Metabolic/Endocrine			
9. Neuropsychiatric			

A. Is there loss or seriously impaired function of any paired organs? Yes _____ No _____
Explain _____

B. Is student under treatment for any medical or emotional condition? Yes _____ No _____
Explain _____

C. Recommendation for physical activity (patient care activities) Unlimited _____ Limited _____
Explain _____

Based on my assessment of this student's physical and emotional health on _____ (Date), he/she appears to be able to participate in the activities of a health profession in a clinical setting and provide safe care to the public.

____ YES ____ NO, please explain _____

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

Office Address **City** **State** **Zip Code**

Healthcare Provider Clinic Stamp Required:

Randolph Community College

Information regarding Criminal Background Check/Drug Screen/Externship For Potential Students

Do NOT obtain this background check or drug screening prior to starting the Course. You are simply signing this form as acknowledgment that this will be required once the course starts.

Paramedic and AEMT Program

All potential student in health occupations programs should be aware that our clinical agencies require the student to complete a national criminal background check and drug screen prior to being allowed into the clinical setting. Specifically, these policies may exclude persons with felony convictions and certain misdemeanor convictions from participating in clinical education at their facility.

Potential students should be aware that this will be their financial responsibility.

My signature below indicates that I am aware of the information regarding the National criminal background check and drug screen being required for entry into clinical facilities. I understand that if I fail to meet certain criteria, as set by these facilities, that I may not be able to participate in clinical education and that this may prevent my successful completion of the program to which I am applying.

_____ _____

Signature Date

_____ _____

Print Name Student ID#

RANDOLPH COMMUNITY COLLEGE
Emergency Medical Services Program

Reading, Writing, and Math Assessment Verification

Appointments are required for testing. Limited same day testing may be available.

Asheboro: Call (336) 633 – 0223 or (336) 633 – 0321

Archdale: Call (336) 862 - 7980

Appointments are available mornings, afternoons, and evenings

Location: Asheboro - Assessment Center (next to the greenhouses; behind the Campus Store)
Archdale –Main Building

Acceptable scores / courses (scores and courses must be less than 3 years old):

Basic EMT

Reading: TABE – GE 11 or higher (9D – 602; 10D – 608; 9A – 598; 10A – 609)
ASSET - 38
Placement into or completion of a college-level English class (ENG 111)

Advanced EMT or Paramedic

Reading & Writing: NCDAP (Accuplacer) – placement into Freshmen English
COMPASS combined score of 151 or higher (placement into a college level English class)
TABE Reading – GE 12.9+ (9D – 622; 10D – 634; 9A – 617; 10A – 628)

Math: NCDAP (Accuplacer) – score of 7 or higher on each DMA 010 / 020 / 030
Completion of DMA 010 / 020 / 030 with a passing grade in each
Completion of MAT 60 or any college Algebra course (within last 5 years)
COMPASS – Pre-Algebra score of 47 or higher
TABE Math – GE 12.9+ (9D – 617; 10D – 618; 9A – 618; 10A – 617)

Take this form with you to your testing appointment.

Please ensure that someone from the Assessment Center signs this form.

Student Name _____ Student ID _____ Date _____

Test Type / Scores / Completed Courses _____

Assessment Center Signature _____