



Jersey City Medical Center/Hudson County Community College
Program for Pre Hospital Medicine: Paramedic
APPLICATION FORM



NOTE: Please fill out the following form. You cannot save the data typed into this form. Please print your completed form, sign where noted, and send with your required documentation.

APPLICATION INSTRUCTIONS

Required Documentation

Applicants must submit **ALL** of the following documentation by the deadline date in order to be considered for acceptance into the Paramedic Science Program.

Completed Application Form (fill out online using Acrobat Reader, then print.)

Copy of High School Diploma or GED

Transcripts from High School and any other Educational Institutions Attended

Copy of Valid Driver's License or State ID (to serve as proof of minimum age requirement of 18 years)

Copy of Current EMT-Basic Certificate and/or National Registry

Copy of Current Healthcare Provider Level CPR Card

Letter of Recommendation (Preferably from someone who can speak to your knowledge as an EMT)

Completed Applicant Health Form (With attached proof of immunizations)

\$65.00 Application Fee (check or money order made payable to Jersey City Medical Center EMS)

Submit all of the above documentation to the following address:

Paramedic Program Coordinator
Jersey City Medical Center
Emergency Medical Services
355 Grand Street
Jersey City, NJ 07302

Application Process

1. Complete a Hudson County Community College application and submit it with a \$15.00 check or money order to:
HCCC Office of Admissions
162 Sip Avenue
Jersey City, NJ 07306
2. Complete a Jersey City Medical Center/Hudson County Community College Program for Pre-Hospital Medicine: Paramedic Science application and submit it with the above-mentioned documentation and application fee.
3. Take the College Placement Test and HOBET (Health Occupations Basic Education Test) when notified by Hudson County Community College. You must schedule an appointment to test by calling the Testing Center at 201-360-4267.
4. Schedule an appointment with your counselor or the HCCC Program Director to set up an initial class schedule. PLEASE DO NOT SCHEDULE THIS APPOINTMENT BEFORE YOU HAVE COMPLETED THE PRE-ADMISSION TESTING.



Jersey City Medical Center
Hudson County Community College
Program for Pre Hospital Medicine: Paramedic



Name (Last, First, Middle Initial)

Social Security Number

Residence Address

Home Phone Number

City

State

Zip

Work Phone Number

Email address

Cell/Pager Number

Name of Nearest Relative

Phone Number

Are you at least 18 years of age?

Yes

☐

No

☐

EMT COURSE INFORMATION

Name of EMT School

Completion Date

State EMT ID Number

Expiration Date

National Registry ID Number

Expiration Date

Name of Primary Instructor

Phone Number

EDUCATION HISTORY

Do you have a:

High School Diploma

☐

GED certificate?

☐

Date Received

Name of High School Attended

City/State

College, University or Graduate School

Name and Location of School

Dates Attended

From/To:

Total Credit Hours
Semester/Quarter

Major/Minor or Subject Area

Degree Received and
Year received

From/To:

From/To:

EMPLOYMENT HISTORY

Current Job Title	Name of Supervisor	Supervisor's Phone Number
Company Name/City State of Employer	Employment Dates From:	Reason for Leaving
	To:	

Duties/Responsibilities

May We Contact Your Current Employer? Yes ☐ No ☐

Job Title	Name of Supervisor	Supervisor's Phone Number
Company Name/City State of Employer	Employment Dates From:	Reason for Leaving:
	To:	

Duties/Responsibilities

May We Contact Your Current Employer? Yes ☐ No ☐

Job Title	Name of Supervisor	Supervisor's Phone Number
Company Name/City State of Employer	Employment Dates From:	Reason for Leaving:
	To:	

Duties/Responsibilities

APPLICANT AUTHORIZATION & CERTIFICATION

I authorize the Jersey City Medical Center/Hudson County Community College Program for Pre-hospital Medicine and its agents to obtain any information relating to the facts provided in this application from schools, employers, criminal justice agencies or other individuals. This information may include but is not necessarily limited to, academic performance, attendance, achievement, personal medical/drug use history, disciplinary action, arrest and conviction records.

I release any employer, including individuals such as record custodians, from any and all liabilities that may result from the release of information to the Jersey City Medical Center/Hudson County Community College Program for Pre-Hospital Medicine.

I certify that the statements provided herein are true to the best of my knowledge. I understand that any incomplete, inaccurate, misleading, false or incorrect information given in this application may result in the rejection of my application. Such information may also render an

acceptance void and/or can be cause for dismissal upon discovery. I agree to submit to all pre-admission testing as required by the Jersey City Medical Center/Hudson County Community College Program for Pre-Hospital Medicine.

Signature _____ Date _____



Jersey City Medical Center/Hudson County Community College
Program for Pre Hospital Medicine: Paramedic
Applicant Health Form



Name Social Security Number

Address

Home Phone Number Work Phone Number

Date of Birth Male ☐ Female ☐

Private Physician's Name

Address

Specialty

Who should we contact in case of an emergency?

Name Relationship

Address

Home Phone Number Work Phone Number

PAST MEDICAL HISTORY

What was the date of your last complete physical exam?

Have you been told you have any medical problems? No ☐ Yes (please explain) ☐

Medications (list any used on a regular basis include birth control medications and non-prescription drugs such as vitamins, cold remedies, aspirin, etc. If none, so state.)

Hospitalizations/Operations/Accidents/Injuries None ☐ Yes - please list date(s) & type(s) ☐

Date	Description

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Have you ever received a transfusion of blood or blood products? No ☐ Yes ☐

If yes, when?

Do you have, or have you ever had any allergies (food, medicine, latex, other)? No ☐ Yes ☐
If yes, please list.

If latex allergy, what type? Localized rash ☐ General hives ☐ Asthma ☐ Nasal/Eye symptoms ☐

How has you latex allergy been diagnosed? ☐ Blood test ☐ Patch test ☐ Other ☐

Do you have any physical limitations or restrictions which affect any of your activities at home or work?

No ☐ Yes (please list) ☐

COMMUNICABLE DISEASES

Have you ever had:

Date:

☐ Measles (Rubeola)	No ☐ Yes ☐	
☐ Mumps	No ☐ Yes ☐	
☐ Rubella (German Measles)	No ☐ Yes ☐	
☐ Chicken Pox	No ☐ Yes ☐	
☐ Hepatitis B	No ☐ Yes ☐	
☐ Tuberculosis	No ☐ Yes ☐	

Last skin test date: Result:

Chest x-ray date: Result:

IMMUNIZATIONS

Date

Submit copy of test results with this form.

Date

☐ Hepatitis B	
☐ Measles	
☐ Mumps	
☐ Rubella	

☐ Tetanus	
☐ Varicella	
☐ Other	
☐ Other	

SOCIAL HISTORY

Tobacco Use

☐ Never	Past age started	☐ Cigarettes # packs per day
	Age stopped	☐ Cigars # per day
	Present age started	☐ Pipe # bowls per day

Alcohol Intake

☐ Beer	# per day	or	# per week	
☐ Wine	# per day	or	# per week	
☐ Spirits	# per day	or	# per week	

Any history of treatment? No ☐ Yes ☐

If yes, please describe:

Drug Use

Have you ever used drugs or been treated for drug use?

No ☐ Yes ☐

If yes, please describe:

OCCUPATIONAL HISTORY

Usual Occupation

Present Job Number of years at present occupation:

Have you been injured in the past year? No ☐ Yes ☐

If yes, give date and describe:

MEDICAL HISTORY

GENERAL	No	Yes	BONES / JOINTS	No	Yes
Night sweats or fever	☐	☐	Neck injury	☐	☐
Recent Weight loss/gain	☐	☐	Neck pain	☐	☐
Blood or bone marrow disease	☐	☐	Back injury	☐	☐
Bleed easily	☐	☐	Back pain	☐	☐
Anemia	☐	☐	Joint injury/pain	☐	☐
Swollen glands	☐	☐	Muscle injury/pain	☐	☐
Problems with immune system	☐	☐	Arthritis	☐	☐
Cancer	☐	☐	Broken bones	☐	☐
Hay fever	☐	☐			
SKIN			NERVES		
Change in any wart or mole	☐	☐	Convulsions/fits, seizures (epilepsy)	☐	☐
Skin diseases	☐	☐	Head injury	☐	☐
If yes, list here:			Memory loss	☐	☐
			Difficulty concentrating	☐	☐
			Numbness/tingling	☐	☐
			Carpal tunnel syndrome	☐	☐
			Fainting/dizzy spells	☐	☐
EYES			Headaches	☐	☐
Wear eyeglasses?	☐	☐	Paralysis	☐	☐
If yes, please specify:			Trouble sleeping	☐	☐
Reading ☐ Distance ☐ Contact lenses ☐			Stress	☐	☐
Both eyes ☐ Left eye only ☐ Right eye only ☐			Depression	☐	☐
Color blindness	☐	☐	Any mental disorder	☐	☐
Cataracts	☐	☐			
Glaucoma	☐	☐	LUNGS		
Vision problems	☐	☐	Shortness of breath	☐	☐
EAR, NOSE, THROAT			Any lung trouble	☐	☐
Hearing problems	☐	☐	If yes, please specify:		
Noise in ears	☐	☐			
Balance problems	☐	☐	Asthma	☐	☐
Sinus problems	☐	☐	Bronchitis	☐	☐
Mouth sores	☐	☐	Pneumonia	☐	☐
Change in voice	☐	☐	Tuberculosis	☐	☐
Hoarseness	☐	☐	Persistent cough	☐	☐
Difficulty swallowing	☐	☐	Cough up blood	☐	☐
			Exposed to second-hand smoke	☐	☐
			If yes, please specify where: Home ☐ Work ☐		

MEDICAL HISTORY (CONTINUED)

	No	Yes		No	Yes
ENDOCRINE			ABDOMEN		
Diabetes	☐	☐	Ulcers	☐	☐
Thyroid problems	☐	☐	Change in bowel habits	☐	☐
If yes, please specify			Hernia	☐	☐
			Nausea/vomiting	☐	☐
			Pain in abdomen	☐	☐
			Liver disease	☐	☐
			Hepatitis/jaundice	☐	☐
HEART			Blood in stools	☐	☐
Chest pain	☐	☐	Black tarry stools	☐	☐
Heart failure	☐	☐	Vomiting of blood	☐	☐
Rheumatic fever	☐	☐	VASCULAR		
Irregular heart beat	☐	☐	Stroke/blood clot	☐	☐
High blood pressure	☐	☐	Varicose veins	☐	☐
Swollen ankles	☐	☐	Cramps in legs with walking	☐	☐
GENITOURINARY					
Blood in urine	☐	☐			
Kidney problems	☐	☐			
Reproductive problems	☐	☐			
Bladder or reproductive infections	☐	☐			
Prostate problems	☐	☐			

OTHER

Please explain any medical problems

COMMENTS

Applicant/Student: I certify that the above information is true and correct to the best of my knowledge.

Signature _____

Date _____

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