



ADMINISTRATION

AD1

System Application

EMR	EMT	AEMT	Intermediate	Paramedic	PHRN	LI
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Full Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip: _____

Phone: _____ SS#: _____

Email: _____

Affiliated Agency: _____

Attach the applicable items:

	EMR	EMT	AEMT	Intermediate	Paramedic	PHRN
SAMIC Agency Affiliation	X	X	X	X	X	X
System Testing and Skill Evaluation	X	X	X	X	X	X
CPR Card	X	X	X	X	X	X
ACLS			X	X	X	X
PALS or PEPP			X	X	X	X
PHTLS, ITLS, TECC, TCCC, or TNS			X	X	X	X

YES NO Have you ever been suspended from an EMS system?

YES NO Are you currently suspended from an EMS System?

YES NO Have you ever been convicted of a felony?

YES NO Are you currently charged with a felony?

System Application

Read and initial each section

_____ I understand that as an EMS Provider in the HSHS St. John's Hospital SAMIC EMS System I must comply with all policies, procedures, and protocols set forth by the EMS Medical Director. I understand that violation of any policy, procedure, and/or protocol is noncompliance with the expected standard of care and such action may result in immediate corrective action, including system suspension and/or revoking privileges to function within the system.

_____ I understand that it is my responsibility to maintain all required certifications as required by the system to maintain good standing and ability to function within the HSHS St. John's Hospital SAMIC EMS System. I understand that if I allow any of the required certifications to expire or lapse for any reason, the system may take action up to and including revoking privileges to function within the system.

_____ I understand that it is solely my responsibility to ensure my EMT license remains current and to file the appropriate paperwork with the EMS office at least 30 days prior to my licensure expiration to ensure my license is renewed in a timely manner. I also understand that I am responsible for maintain current and accurate records of my EMS continuing education.

Applicant Affidavit:

I certify that the information contained in this application is correct to the best of my knowledge. I understand that to falsify information is grounds for refusing entry in the HSHS St. John's Hospital SAMIC EMS System or for suspension/termination from the system should I be accepted into the System.

Signature of Applicant: _____ Date: _____

Printed Name: _____

EMS Office Use Only

Protocol Exam Completion Score: _____ Date: _____

Skill Evaluation Completion Date: _____ Evaluator: _____

Notes _____