



PARAMEDIC

HEALTH INFORMATION CHECKLIST FOR NEW ADMISSIONS

All Health information paperwork, background check, and drug test must be submitted to:
 Deb Heidlebaugh, Records Clerk in Warf 130-A. [Office: 931.540.2849 Fax: 931.560.4103]

ALL paperwork MUST be in the office of EMS Education by AUGUST 5th

This check list is to help you in completing all paperwork to be turned in.

COMPLETE NOW

- A. Completed Vaccination Verification form and State of Tennessee Medical Statement _____
- B. TB Skin Test (2-step) _____
 (2nd part to be completed 1-4 weeks after initial TB; initial TB within 3 months of 1st day of class)
- C. Chest X-ray _____
 (Only if positive TB Skin Test)
- D. MMR (Rubella, Rubeola, & Mumps Titer (IGG) (Attach lab reports) _____
- E. Varicella Zoster (IGG) Titer (Attach lab reports) _____
- F. Tetanus/Diphtheria Booster (within 10 yrs) _____
- G. Hepatitis B Vaccine Series _____
- H. Hepatitis B Titer (Required 60 days after Hepatitis B series) _____
- I. Current BLS for Healthcare Provider Card _____
- J. Current Health Insurance Card _____
- K. Current EMT License _____

- L. **Background Check & Drug Screen [Not before July 1st]*** _____

- M. Seasonal Flu Shot (**NOT** to be completed until September) _____

- N. Online General and Site Specific orientation & quiz results _____
[Will be emailed to you when available]

** To obtain a Criminal Background Check and/or Drug Screen please go to www.columbiastate.edu/ems-incoming-students [Verified Credentials or Certified Background Checks] Refer to the website for a local One-Stop-Shop locally.*



Columbia State Community College—Health Science Division

HEALTH SCIENCE STUDENT DRUG SCREEN FORM

POLICY: “A drug screen is required after acceptance into specific health science programs. Since multiple facilities utilized for clinical experience require a drug screen of all applicants for employment, students rotating in the clinical environment are subject to the same standards.”

PHYSICIAN AUTHORIZATION

I request the laboratory to perform a common drug screen on the student listed below.

Physician Signature _____

Physician Name (printed or typed) _____

Date _____

STUDENT RELEASE I hereby grant permission to the physician and/or laboratory to release the results of my minimum 10 Panel drug screen to Columbia State Community College. I also grant permission to Columbia State to release the results to clinical affiliate institutions.

Signature _____

Name (printed or typed) _____

Social Security Number _____

Address _____

City, State, Zip _____

Program to which you have been accepted _____

Date _____

INSTRUCTION TO LAB: THE TEST MUST BE A MINIMAL 10 PANEL DRUG SCREEN

Columbia State Community College is not responsible for any fees related to student physical exams, blood work, or drug screens. Correspondence regarding fees should be directed to the student. The drug screen results and this form are to be sent to Columbia State Community College.

PROVIDERS, please send this form and a copy of the drug screen results to:

COLUMBIA STATE COMMUNITY COLLEGE

ATTENTION: Deb Heidlebaugh, Health Science Records Clerk

Warf Bldg, Suite 130-A

1665 Hampshire Pike

Columbia, TN 38401

Phone: (931) 540-2849 Fax: (931) 560-4103

COLUMBIA STATE POLICY & PROCEDURE FOR STUDENTS ACCEPTED INTO A HEALTH SCIENCE PROGRAMS IS AS FOLLOWS:

Drug Screening

A drug screen will be required for students after acceptance into health science programs as a condition for beginning clinical education. Recognized clinical affiliates have agreed to accept a minimum **10 panel drug screen**. Since multiple facilities utilized for clinical experience require a drug screen of all applicants for employment, students rotating in the clinical environment are subject to the same standards.

A positive drug screen will result in the student being excluded from clinical attendance. In this case the student will be counseled to withdraw or will ultimately earn a failing grade based on inability to complete the clinical requirements for the program.

Every student accepted into a program may have (but not required) a physician authorize the attached form marked "Health Science Student Drug Screen form." **You may have your private physician perform the drug screen or you may obtain the drug screening through an independent laboratory that offers this service. Drug screening service must involve a certified medical review officer (MRO).** Some facilities in the Columbia area that provide this service are:

- | | | |
|---|---|-------------------------------------|
| ▼ | Maury Regional Hospital, Northside Office:
1600 Nashville Hwy, Columbia, TN 38401 | "10 Panel"
Phone: (931) 540-4270 |
| ▼ | Rapid Care
129 North Locust Street – Suite A
Lawrenceburg, TN 38464 | "10 Panel"
Phone: (931) 762-7232 |
| ▼ | Workers Health and Walk-In Clinic
Dr. Caleb Wallwork
1223 Hatcher Lane, Columbia, TN 38401
[Non-listed collection site for Verified Credentials ONLY when ordering online] | "10 Panel"
Phone: (931) 840-4200 |
| ▼ | Universal Screen
2500 Cayer Layne, Suite C, Unit 2
Columbia, TN 38401 | "10 Panel"
Phone: (931) 589-0045 |

IMPORTANT NOTICES

- The drug screen must be completed and the results must be on file at Columbia State Community College by date designated by program.
- The cost for the drug screen is each student's responsibility.
- **Drug screens typically will not be paid by insurance.**



PARAMEDIC Vaccination Verification Form

Name of Student: _____ SS# _____
Please Print

Date: _____ Phone: _____ Cell: _____

NOTE: Attach all Lab and Radiology reports to this form.

Date of T.B. skin test **(required)**: _____ Date Administered: _____ Date Read: _____ Result: _____
Date Administered: _____ Date Read: _____ Result: _____

**NOTE: 2-step TB skin test (Interdermal test; check within 48-72 hours and repeat process after 3 weeks.)
TB skin test MUST BE STARTED within 2 months of the start of classes.**

NOTE: If T.B. skin test is positive; you must submit a chest X-ray report. Date: _____ Results: _____
(Must be within 6 months of clinical) **(Attach Radiologist's report)**

Date of Rubeola Titer/IGG **(required)** _____ **Attach lab report for result:** _____

Date of Mumps Titer/IGG **(required)** _____ **Attach lab report for result:** _____

Date of Rubella Titer/IGG **(required)** _____ **Attach lab report for result:** _____

2 MMR **(required if not immune to any of 2 above)** Date #1 _____ Date #2 _____

Date of Varicella Zoster titer/IGG **(required)** _____ **Attach lab report for result:** _____

If NOT immune: Date of Varicella Zoster immunization #1: _____ #2: _____

Date of Flu Immunization **(required)**: _____ (Flu shots become available in October)

Have you had chicken pox? YES _____ NO/NOT SURE _____

Date of Tetanus **(required)**: _____ *You must have a booster if your vaccination is over 10 years old*

Date of Hepatitis B series (received): #1 _____ #2 _____ #3 _____ **AND**

Date of Hepatitis B titer _____

(Required if you have had the series) (Attach Hepatitis B titer lab report for results). _____

_____, M.D.

Physician's Signature

_____, M.D.

Print or type Physician's Name

Physician's Address



STATE OF TENNESSEE
 DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
 425 FIFTH AVENUE, NORTH
 CORDELL BUILDING, FIRST FLOOR
 NASHVILLE, TENNESSEE 37247-0701

MEDICAL STATEMENT
For Emergency Medical Services Professional License

The Division of Emergency Medical Services is the state agency responsible for the licensing of emergency medical services personnel. The mission of the agency is to oversee the delivery of pre-hospital emergency care and to safeguard the public from inappropriate or incompetent medical care in the pre-hospital environment. When issuing a license, it is understood that the individual can meet the demands, duties, and responsibilities listed below.

GENERAL DUTY REQUIREMENTS:

The general environmental conditions in which emergency medical service personnel work includes a variety of hot and cold temperatures and, at times, they may be exposed to hazardous fumes. They may be required to walk, climb, crawl, bend, pull, push, or lift and balance over less than ideal terrain. They can also be exposed to a variety of noise levels, which can be quite high, particularly when sirens are sounding. The individual must be able to function effectively in uncontrolled environments with high levels of ambient noise. Aptitudes required for work of this nature are good physical stamina, endurance, and body condition which would not be adversely affected by having times to lift, move, carry and balance while moving in excess of 125 pounds (250 pounds 2 person lift). Motor Coordination is dexterity to bandage, splint and move patients, including properly applying invasive airways and administering injections.

Driving in a safe manner, accurately discerning street names, map reading, and the ability to correctly distinguish house numbers or business locations are essential tasks. Use of the telephone or radio for transmitting and responding to physician's advice is also essential. The ability to concisely and accurately describe orally to health professionals the patient's condition is critical. The provider must also be able to accurately summarize all data in the form of a written report.

TYPE APPLICANTS NAME

HAS BEEN EXAMINED AND DEMONSTRATES SUFFICIENT HEALTH TO PERFORM THE ESSENTIAL FUNCTIONS IN THE PRE-HOSPITAL ENVIRONMENT AS DESCRIBED IN THE GENERAL DUTY REQUIREMENTS ABOVE INCLUDING VISUAL ACUITY, SPEECH, HEARING, AND THE USE OF EXTREMITIES.

PRINT PHYSICIAN'S NAME

PHYSICIAN'S LICENSE NUMBER

STATE

PHYSICIAN'S SIGNATURE

DATE

AUTHORIZATION FOR RELEASE OF INFORMATION:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION BY THE EXAMINER NECESSARY FOR QUALIFICATION TO MY EMPLOYER FOR DETERMINATION OF MY ELIGIBILITY BY THE DIVISION OF EMERGENCY MEDICAL SERVICES.

SIGNATURE OF APPLICANT

SOCIAL SECURITY NUMBER

DATE

“Under HIPPA, the health information you furnish on this document is protected from public inspection, absent a subpoena or for purposes of health oversight activities.”



Paramedic

Uniform Shirt Order Form

Name: _____ Phone # _____

Address: _____

Email address: _____

Check: Men's Women's

Item	Size	Quantity	Price ea.	Total
DARK GREEN Paramedic Shirt S-XL			\$21.00	
DARK GREEN Paramedic Shirt 2XL	2XL		\$23.00	
DARK GREEN Paramedic Shirt 3XL	3XL		\$25.00	

Order forms may be submitted in person or faxed to:

Ted's Sporting Goods
806 South Main
Columbia, TN 38401
Phone: (931) 388-6387
Fax: (931) 540-8085