

Dear EMS Applicant,

Thank you for your interest in Pontotoc Technology Center's EMS programs. This packet contains all the information and forms that you need to complete the application process. The requested information is critical for a student's successful completion of our programs, because much of the information is required by the various organizations that we work with during your educational process. It is essential that you complete all of the forms and return the packet along with the required documentation before the application deadline. Only applicants with completed application packets will be enrolled into the program.

The forms and documents required for the application process can be confusing and the task of gathering the various documents can be time consuming. Applicants that wait till the last minute to complete the packet often are not accepted into the program. Allow yourself at least 3 weeks to complete the application. Our staff and instructors are dedicated to helping you reach your career goals and the information that you provide us will ultimately determine your overall success in the program.

Several places can assist you with the required immunization, including your personal physician and the local health department.

If you have any questions, please contact me at (580)310-2276 or email me [jwood@pontotoctech.edu](mailto:jwood@pontotoctech.edu)

Jay Wood

Fire & Safety Industrial Coordinator

Pontotoc Technology Center

## Pontotoc Technology Center EMT Course

### Program Information:

The EMT Course includes a minimum of 260 hours of classroom, clinical, and lab instruction. Upon successful completion of this course the student is eligible to sit for the National Registry and State Licensure Examination at the basic level. Those who complete the course are prepared to work as an entry-level EMT for ambulance services and fire departments statewide. This course is the foundation course that serves as a stepping stone to paramedic certification. Students must apply for acceptance into the program prior to enrollment. Course work includes anatomy, physiology, assessment and trauma care. Successful completion prepares for the State Licensure and National Registry examinations.

Applicants must complete an application packet and return it to the Health Program Coordinator prior to the end of the application deadline. See the Application Check Off Form for a list of what is needed to enroll in this course.

### Criminal History Report:

All EMS applicants are required to provide a criminal history report. (Instructions and form included). Only original forms sent to you from the OSBI will be accepted. Any "rap sheets" sent by the OSBI must be included with your application. This process can take up to three weeks by mail. The OSBI does accept requests in person and the process typically takes only a few minutes. You must have the fingerprint check run as well.

*\*History of conviction of a felony is not acceptable by our program, however, you have the right to request a hearing by OSDH/ EMS Division to challenge licensure with a felony conviction.*

### Immunizations:

All EMS students are required to show proof of current immunizations (list and forms attached.). Applicants are reminded to follow the required list closely. If you have any questions about immunizations please contact the Health Programs Coordinator. For more information on Immunizations and Vaccinations, visit the CDC website. [www.cdc.gov](http://www.cdc.gov)

### Payment Information:

Tuition/financial arrangements must be made prior to enrollment. Refer to current PTC Course Catalog for current prices (the catalog is available on [www.pontotoctech.edu](http://www.pontotoctech.edu)). Prices are subject to change without notice.

### Other fees to be paid to entities other than PTC:

Refer to the OSDH\EMS and NREMT websites for current Licensure and testing fees. All fees are subject to change without notice.

Items that we could not forecast the cost for are: immunizations, Cargo pants, Jump Boots, Black belt, and if you take AHA CPR elsewhere.

\*\*\*Dropping, leaving, quitting or being removed from the program, no matter what the reason, will likely constitute a forfeiture of all tuition paid.

\*\*\*No refunds after the second day of class regardless of attendance. No refunds on books or supplies.

*NON-DISCRIMINATION STATEMENT: Pontotoc Technology Center, in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 and Title IX of the Education Amendment of 1972, does not discriminate on the basis of race, ethnicity, religion, national origin, age, gender, disability or veteran status in any of its policies, practices or procedures. These equal opportunity provisions include, but are not limited to admissions, employment, financial aid and student services.*

Revised July 2015

Pontotoc Technology Center  
Application Self Check Off Form

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

The following items are required for your acceptance into the EMT-Basic Program. This page is provided for you to "check off" the items as you place them into your application packet. You must complete, sign and include this page along with all of the listed documents with your application forms for consideration of admission. Applicants may be given the opportunity to provide additional or corrected documentation prior to the start of class.

- Completed BIS Admission/EMT Application form
- Copy of valid state Driver's License (Must be 18 years of age)
- Copy of current CPR card
- Show Social Security Card to person taking your packet
- Copy of H.S. Diploma, transcript or GED (or college transcript)
- Record of receiving first MMR immunization
- Record of receiving second MMR immunization
- Record of first Tuberculin Skin Test (use form in packet)
- Record of second Tuberculin Skin Test (use form in packet)
- Record of Chest X-Ray reading (only if positive Tuberculin Skin Test)
- Record of Hepatitis B series or completed Declination form
- Record of Varicella Immunization or Documentation form completed
- Copy of OSBI Background Check with fingerprints *results* (you must get results from OSBI)
- Signed Drug/Alcohol Screen form
- Certificate of completion for NIMS 100, NIMS 700 and HAZWOPER ([www.training.fema.gov/is/nims.asp](http://www.training.fema.gov/is/nims.asp))

I \_\_\_\_\_ understand that the above requested items are a mandatory  
Applicant Name

requirement of the EMT-Basic Program. Failure to include ALL of these items in my application packet WILL result in my application being possibly rejected.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**BUSINESS & INDUSTRY SERVICES / PONTOTOC TECHNOLOGY CENTER**  
**ENROLLMENT FORM** *ALL Enrollment forms should be faxed to (580) 310-2295 if not completed in person*

**PLEASE COMPLETE THIS SECTION IN FULL**

COURSE DATE	COURSE TIME	COURSE NAME	CONTRACT #	COURSE CODE
LAST NAME		FIRST NAME		M.I.
SSN		E-MAIL		
HOME PHONE			WORK PHONE	
ADDRESS		CITY	STATE	ZIP CODE
PLEASE CHECK THE SCHOOL DISTRICT IN WHICH YOU LIVE.			PLEASE CHECK THE HIGHEST EDUCATION LEVEL ACHIEVED.	
<input type="checkbox"/> Ada <input type="checkbox"/> Allen <input type="checkbox"/> Byng <input type="checkbox"/> Latta <input type="checkbox"/> McLish <input type="checkbox"/> Pickett-Center		<input type="checkbox"/> Roff <input type="checkbox"/> Sasakwa <input type="checkbox"/> Stonewall <input type="checkbox"/> Tupelo <input type="checkbox"/> Vanoss <input type="checkbox"/> Other _____	<input type="checkbox"/> (30) Less than a H.S. diploma <input type="checkbox"/> (31) High School graduate <input type="checkbox"/> (32) Some college, no degree <input type="checkbox"/> (33) Technical diploma <input type="checkbox"/> (34) Associate degree <input type="checkbox"/> (35) Bachelor degree <input type="checkbox"/> (36) Master degree <input type="checkbox"/> (37) Doctorate degree <input type="checkbox"/> (38) GED	
PAYMENT METHOD		<input type="checkbox"/> Discover	<input type="checkbox"/> Master Card	<input type="checkbox"/> Visa
CASH / Check / Money Order Receipt # _____				
EMPLOYER'S NAME OR FUNDING AGENCY OR PAYING OWN FEES (write Self-Pay)				

BIRTHDATE	RACE (PLEASE CHECK ALL THAT APPLY) <input type="checkbox"/> (3) White <input type="checkbox"/> (0) American Indian or Alaska Native <input type="checkbox"/> (1) Black or African American <input type="checkbox"/> (2) Hispanic/Latino <input type="checkbox"/> (4) Asian <input type="checkbox"/> (5) Native Hawaiian or other Pacific Islander <input type="checkbox"/> (6) Other
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	<i>Pontotoc Technology Center, in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 and Title IX of the Education Amendment of 1972, does not discriminate on the basis of race, ethnicity, religion, national origin, age, gender, disability or veteran status in any of its policies, practices or procedures. These equal opportunity provisions include, but are not limited to admissions, employment, financial aid and student services.</i>

**THIS SECTION IS REQUIRED FOR CHICKASAW NATION EMPLOYEES ONLY**

PLEASE CHECK ONE OF THE DIVISIONS BELOW.

<b>HEADQUARTERS (A-L)</b> <input type="checkbox"/> (A) Division of Administrative Services <input type="checkbox"/> (B) Division of Aging <input type="checkbox"/> (C) Division of Arts and Humanities <input type="checkbox"/> (D) Division of Communications <input type="checkbox"/> (E) Division of Education and Training <input type="checkbox"/> (F) Division of Facilities and Support <input type="checkbox"/> (G) Division of Heritage Preservation	<input type="checkbox"/> (H) Division of Legal Services <input type="checkbox"/> (I) Division of Program Operations <input type="checkbox"/> (J) Division of Youth & Family Services <input type="checkbox"/> (K) Division of Treasury <input type="checkbox"/> (L) Other _____
<b>OTHER DIVISIONS (M-O)</b> <input type="checkbox"/> (M) Division of Commerce (Chickasaw Enterprises) <input type="checkbox"/> (N) Division of Housing & Tribal Development <input type="checkbox"/> (O) Division of Health Systems	

CHICKASAW EMPLOYEE SIGNATURE	NAME OF YOUR DEPARTMENT	JOB TITLE
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<i>I acknowledge that my department will be billed for the class for which I am enrolling. I understand that if I cannot attend, I must give at least twenty-four (24) hours notice or my department will be billed regardless of attendance.</i>	SUPERVISOR SIGNATURE: _____
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RETURN TO: Chickasaw Nation Training Division	ACCOUNT NUMBER: _____
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**PHOTO RELEASE:**

I hereby give Pontotoc Technology Center the absolute right and permission to publish photographic pictures of me, in which I may be included in whole or in part, in advertising, promotional or other lawful purposes whatsoever.

Signature \_\_\_\_\_

Person to be notified in the event of an emergency:  
 Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Previous EMS Education (If Applicable)  
 Level of current EMS licensure: \_\_\_\_\_ State(s) licensed/certified in: \_\_\_\_\_  
*(Note: copies of all licenses/certificates MUST be submitted with this application.)*

**General Information:**

Do you have any physical, medical or personal condition/problems which would:

Jeopardize patient health or safety? Yes \_\_\_ No \_\_\_  
 Jeopardize your own health or safety? Yes \_\_\_ No \_\_\_

Have you ever been convicted of a felony? Yes \_\_\_ No \_\_\_

Have you ever served a jail or prison sentence, or been on court probation?  
 Yes \_\_\_ No \_\_\_

If you have "Yes" on any of these questions, please explain:  
 \_\_\_\_\_  
 \_\_\_\_\_

References: Give the names, addresses and phone numbers of two (2) unrelated persons (an employer, recent teacher, counselor or co-worker), who knows you well and can give information about you:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Address: \_\_\_\_\_

Any Additional Information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

The Pontotoc Technology Center, in compliance with the Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1974, does not discriminate on the basis of race, color, religion, creed, national origin, age or sex in any of its policies, practices, or procedures. These equal opportunity provisions include but are not limited to admissions, employment, financial aids, and student services.

I HAVE BEEN INFORMED AND AM FULLY AWARE OF THE PREREQUISITES TO THE PROGRAM.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Varicella (Chicken Pox) Documentation

Varicella Immunization (chicken pox) or signed documentation with dates of disease. If no immunization or dates of disease are available a titer test may be required.

\*\*\*\*\*

I \_\_\_\_\_ do verify that  
(Signature of Student or Signature of Parent/Guardian)

\_\_\_\_\_ had the disease  
(STUDENT NAME- PLEASE PRINT)

Varicella (also known as Chicken Pox) in 19\_\_\_\_ at the age of \_\_\_\_\_.

\_\_\_\_\_  
(SIGNATURE)

\*\*\*\*\*

### Hepatitis B Declination

Name: \_\_\_\_\_

Program: \_\_\_\_\_

#### Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B (HBV) infection. I have received information about hepatitis B vaccine, and I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine. I further understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with hepatitis B vaccine, I will make my own arrangements to receive the vaccine.

- I decline hepatitis B vaccine.
- I have already received the hepatitis B vaccine.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Pontotoc Technology Center  
PPD/TST Form**

Student Name: \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Location (circle):      Left or Right      Forearm or Trapezius

Medication used: \_\_\_\_\_

Lot #: \_\_\_\_\_

Signature: \_\_\_\_\_

**Reading**

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Reactive \_\_\_\_\_

Non-Reactive \_\_\_\_\_

Signature: \_\_\_\_\_

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**Pontotoc Technology Center  
PPD/TST Form**

Student Name: \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Location (circle):      Left or Right      Forearm or Trapezius

Medication used: \_\_\_\_\_

Lot #: \_\_\_\_\_

Signature: \_\_\_\_\_

**Reading**

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Reactive \_\_\_\_\_

Non-Reactive \_\_\_\_\_

Signature: \_\_\_\_\_

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CONSENT FOR HEALTH PROGRAMS DRUG/ALCOHOL SCREEN:

(Applicant will read each statement and sign below. Pontotoc Technology Center reserves the right to deny a student admission to any Medical Program if student refuses to sign this consent form.)

1. In applying for admission to any medical program at Pontotoc Technology Center, I understand that a drug/ alcohol screening test could be administered based on suspicion of drugs or alcohol at school or at a clinical site.
2. The drug/ alcohol test will consist of an initial screening test and a confirmatory test for any sample that produces a positive result. The drug/ alcohol testing is to be done within 24 hours of suspicion. Once you enter the drug testing facility, you cannot leave the facility until the sample is collected.
3. The undersigned hereby authorizes the designated drug testing facility to perform a drug/ alcohol screening test as a requirement to stay in any medical program if suspicion exists.
4. I understand the presence of chemical substances in my body fluids may result in dismissal from any medical program at Pontotoc Technology Center.

I hereby authorize that the results of the drug/ alcohol screening test be given to officials at Pontotoc Technology Center for review of continued enrollment in the medical programs. I release and hold Pontotoc Technology Center, its agents, and employees harmless for any action in taking or testing of the sample. I also release and hold harmless Pontotoc Technology Center, its board of education, superintendent, management, instructors, or any other agent or employee for the use of any information received as a result of the screening test process.

I also acknowledge that an offer of admission and continued enrollment to any health program will be contingent upon my submission to and the subsequent results of this drug/ alcohol screen.

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Printed Name

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Applicant Signature

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Date



**OKLAHOMA STATE BUREAU OF INVESTIGATION**

Criminal History Record Information Request  
 6600 North Harvey Place  
 Oklahoma City, OK 73116  
 (405) 848-6724  
 (405) 879-2503 FAX  
[http://www.ok.gov/osbi/Criminal\\_History/](http://www.ok.gov/osbi/Criminal_History/)

**Type Of Search Requested:**

Name Based - \$15.00

Sex Offender - \$2.00

Mary Ripley Violent Offender - \$2.00

State Fingerprint-based - \$19.00  
*\* Must provide fingerprint card.  
 \* Includes name based search.*

DATE \_\_\_\_\_

Request Submitted via:  
 Fax  Mail  In Person

*Requests will be returned in the manner received.*

*Mail requests should include postage-paid reply envelope.*

*Fax requests must include payment by credit card and a dedicated Fax Phone Line for return of completed search.*

( ) \_\_\_\_\_

**ACCEPTABLE FORMS OF PAYMENT:**  CASH  CASHIER'S CHECK / MONEY ORDER

BUSINESS CHECK *No Personal Checks Accepted.*  CREDIT CARD *For Visa, MasterCard and Discover, security code is 3 digits on back of card. For Amex, security code is 4 digits on front. These are the only cards accepted.*

CREDIT CARD # \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_ SECURITY CODE \_\_\_\_\_

CARD HOLDER \_\_\_\_\_  
*Please print the name of the individual card holder as it appears on the credit card.*

CARD HOLDER SIGNATURE (REQUIRED) \_\_\_\_\_

**REQUESTOR INFORMATION: (Type or print clearly in blue or black ink)**

REQUESTOR'S NAME \_\_\_\_\_ SIGNATURE OF REQUESTING PARTY \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE NUMBER ( ) \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_  
*Requestors outside of the United States are strongly encouraged to provide an e-mail address for purposes of correspondence.*

PURPOSE OF REQUEST \_\_\_\_\_

**SUBJECT INFORMATION: (Type or print clearly in blue or black ink)**  
*Forms with corrections done with white out or by striking through the fields in this section will not be processed.*

NAME \_\_\_\_\_  
LAST FIRST MIDDLE

ALIAS/MAIDEN NAME(S) \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ (MM/DD/YYYY). *If date of birth is unavailable, include exact age of subject.*

RACE \_\_\_\_\_ SEX \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

**SEARCH RESULTS (Please do not write in the spaces below):**

Oklahoma State Bureau of Investigation  
 Computerized Criminal History

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Oklahoma Department of Corrections  
 Sex Offender

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Oklahoma Department of Corrections  
 Violent Offender

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*Unless fingerprint cards are provided, record information is furnished solely on the basis of name or description similarity with the subject of your inquiry.*

## EMS PROGRAMS CRIMINAL RECORDS CHECK POLICY

Health care providers are entrusted with the health, safety, and welfare of patients; have access to controlled substances and confidential information; and operate in settings that require the exercise of good judgment and ethical behavior. Clinical facilities are increasingly required by accreditation agencies, such as Joint Commission for Accreditation of Healthcare Organizations (JACHO), to conduct background checks on individuals who provide services within the facility and especially those who supervise records check for all prospective employees for positions where the individual will be caring for older adults or children.

Clinical learning experiences are an essential element of the curriculum of health care programs. All students enrolled in Pontotoc Technology Center's health care programs must successfully complete a criminal records check as a criterion for participating in clinical courses. Participation in clinical courses is required for progression and completion of health care programs.

The check must be completed by the Oklahoma State Bureau Investigation (OSBI). The criminal records check must be completed within the six months immediately prior to the student's entry into clinical courses. The student shall be responsible for all costs associated with the criminal records check.

The information provided in the criminal records report will only be used to evaluate the student's qualifications for entry into clinical courses. Reports will be kept in secured confidential files separate from the student's academic file with access limited to approved members of the Adult Training and Development Division.

Criminal record reports will undergo administrative review. If a student has been convicted of or pled guilty to a disqualifying offense (or any substantially equivalent offenses in any state), the student may be unable to complete clinical learning experiences and may therefore be disqualified from admission, readmission, or progression in the health care program. Some of the disqualifying offenses are absolute bars while others might bar the student from admission, readmission or progression in the program. The absolute and potentially disqualifying offenses are listed in the table attached to this packet.

In the event that the student's background check includes a disqualifying offense, the student will be asked to schedule a meeting with the Program Coordinator to discuss the information received. If the background check identifies offenses that the student considers incorrect, the concerns or issues must be addressed, by the student, to the Oklahoma State Bureau Investigation for resolution. If the background check identifies offenses that may preclude admission, the student will be given an opportunity to respond to the information. Relevant considerations may include but are not limited to: the date, nature and number of convictions; the relationship the conviction bears to the duties and responsibilities of the health care provider; and successful efforts toward rehabilitation. The decision to allow or disallow participation in a clinical course for a student whose background check includes a disqualifying offense is solely at the discretion of the Program Coordinator and the Director of Business and Industry.

All students who are admitted to a health care program have a continual obligation to report any criminal conviction that may impact the student's continued ability to participate in the clinical program to the Program Coordinator or the Director of Business and Industry within 30 days of its occurrence. Failure to do so will result in immediate dismissal from the program.

**ABSOLUTE\* AND POTENTIALLY DISQUALIFYING OFFENSES  
THAT MAY PREVENT AN APPLICANT FROM OBTAINING A  
HEALTH RELATED OKLAHOMA LICENSURE OR CERTIFICATE**

Aggravated Murder *	Compelling Prostitution	Unlawful Abortion
Murder*	Promoting Prostitution	Endangering Children
Voluntary Manslaughter*	Procuring	Contributing to the Unruliness or Delinquency of a Child
Involuntary Manslaughter	Prostitution	Domestic Violence
Felonious Assault*	Disseminating Matter Harmful to Juveniles	Prohibition of Conveyance of Certain Items onto Grounds of Detention Facility or Mental Health or Mental Retardation and Developmental Disabilities Facility.
Aggravated Assault	Pandering Obscenity	Carrying Concealed Weapons
Assault	Pandering Obscenity Involving a Minor	Having Weapon while under Disability
Failure to Provide for a Functionally Impaired Person	Pandering Sexually Oriented Matter Involving Minor	Improperly Discharging a Firearm/Habitation or School
Aggravated Menacing	Illegal Use of a Minor in Nudity- Oriented Material or Performance	Corrupting Another With Drugs
Patient abuse or neglect	Aggravated Arson*	Drug Trafficking Offenses
Kidnapping*	Aggravated Robbery*	Illegal Manufacturing of Drugs
Abduction	Robbery	Funding Drug Trafficking
Child Stealing	Aggravated Burglary*	Illegal Administration or Distribution of Anabolic Steroids
Criminal Child Enticement	Burglary	Drug Abuse
Coercion	Breaking and Entering	Permitting Drug Abuse
Extortion	Theft, Aggravated Theft	Deception to Obtain Dangerous Drugs
Rape*	Unauthorized Use of a Vehicle	Illegal Processing of Drug Documents
Sexual Battery*	Unauthorized Use of Property/Unauthorized Access to Computer Systems	Adulteration of Food
Corruption of a Minor	Passing Bad Checks	
Gross Sexual Imposition*	Misuse of Credit Cards	
Sexual Imposition	Forgery	
Importuning	Medicaid Fraud	
Voyeurism	Securing Writings by Deception	
Public Indecency	Insurance Fraud	
Felonious Sexual Penetration	Receiving Stolen Property	

\*Absolute disqualifying offense