

# Student Application Check List

## Emergency Medical Technician

Student Name: \_\_\_\_\_ Desired Term: \_\_\_\_\_

Please review the required items below and gather the documents. Once all requirements are met, complete the EMT Student Application by scanning the QR code on the next page.

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### *Documents provided in this form or student should have. Read and sign.*

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- Photocopy of government ID (Driver's License, Passport, etc.)
- EMT Student Information
- Uniform Policy Agreement
- Course Commitment
- Physical Attestation – can be signed by student
- EMT Student PPE Training
- Background and Criminal History Acknowledgment
- Emergency Contact Form
- Media Release Waiver
- McCormick Student Agreement
- McCormick HIPAA Waiver

### *Complete these courses and provide copies of the certificates.*

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- ICS 100 Certificate – Free online course *on the FEMA website*
- ICS 700 Certificate – Free online course *on the FEMA website*
- BLS Provider Certificate with at least 6 months before expiration from date of application submission (American Heart Association or American Red Cross).  
→ *proof of enrollment in ALD HTH 021 prior to course start date is acceptable.*

### *Immunization card, medical records, or lab results.*

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- Measles, Mumps, Rubella (MMR) – 2 vaccinations OR a positive antibody titer result
- Varicella (Chickenpox) – 2 vaccinations OR a positive antibody titer result
- Tdap Vaccine – within last 10 years
- Tuberculosis – Negative skin test within last 12 months OR negative chest x-ray
- Influenza Shot – must show current season's shot *OR declination*
- Hepatitis B – 3 step vaccination OR a positive titer result *OR declination*
- COVID-19 – Proof of vaccination *or declination*

- 1 Register as a student at West LA by [applying online today](#).
- 2 Access your LACCD.EDU email address.
- 3 Gather all completed documents and ensure they are complete.
- 4 Scan the QR to complete the EMT Student Application.

## WLAC EMT Student Application



## EMT Student Information

Course Section: \_\_\_\_\_ Semester: \_\_\_\_\_ Year: \_\_\_\_\_

Student ID: \_\_\_\_\_ SSN (last 4): \_\_\_\_\_

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

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

Background about myself:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My motivation(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My career goals:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# EMT Uniform Policy Agreement

## POPP Cohorts

- \_\_\_ I understand that the uniform for this course consists of black leather or leather-like work boot, black leather belt, POPP-issued khaki pants, POPP-issued navy blue sweatshirts and/or navy blue t-shirts, a wristwatch and my West LA student ID name badge.
- \_\_\_ I understand that the ONLY permitted jewelry is a wedding ring and/or reasonably sized stud earrings (one in each ear, no larger than a pencil eraser). I will remove all other visible piercings for class functions, clinical rotations, and any other time I am required to be in uniform.
- \_\_\_ I understand that facial hair must be in compliance with OSHA standards. Mustaches are allowed and should be neatly groomed. Mustaches should not extend beyond the plane of the lower lip and should not interfere with a respirator seal on the face. Beards are not allowed due to the interference with a respirator.
- \_\_\_ I understand that facial hair should be clean shaven for all class functions and clinical hours.
- \_\_\_ I understand that ALL students with long hair should have their hair pulled back at all times.
- \_\_\_ I understand that uniforms should look presentable at all times, including a neatly pressed, clean shirt that is tucked in with a visible West Los Angeles College student name tag.
- \_\_\_ I understand that ONLY a complete uniform is acceptable for this class.
- \_\_\_ I understand that ONLY approved program uniform attire can be worn while in class, outside of class on breaks or class functions, during my hospital and ambulance rotations, during Open Lab and any other class related function where the uniform is appropriate.
- \_\_\_ I understand that I may be asked to leave class if I am not in the correct uniform and that I will not be given credit for the day's hours.
- \_\_\_ I understand that a uniform being cleaned or laundered is not an acceptable reason to be out of uniform.
- \_\_\_ I understand and agree to all terms of the West Los Angeles College EMT Uniform Agreement.

Student's Printed Name: \_\_\_\_\_

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **EMT Uniform Policy Agreement**

- I understand that the uniform for this course consists of black leather or leather-like work boot, black leather belt, navy blue work pant, an embroidered white program uniform shirt with plain white undershirt, a wristwatch and my West LA student ID name badge.
  
- I understand that the ONLY permitted jewelry is a wedding ring and/or reasonably sized stud earrings (one in each ear, no larger than a pencil eraser). I will remove all other visible piercings for class functions, clinical rotations, and any other time I am required to be in uniform.
  
- I understand that facial hair must be in compliance with OSHA standards. Mustaches are allowed and should be neatly groomed. Mustaches should not extend beyond the plane of the lower lip and should not interfere with a respirator seal on the face. Beards are not allowed due to the interference with a respirator.
  
- I understand that facial hair should be clean shaven for all class functions and clinical hours.
  
- I understand that ALL students with long hair should have their hair pulled back at all times.
  
- I understand that uniforms should look presentable at all times, including a neatly pressed, clean shirt that is tucked in with a visible West Los Angeles College student name tag.
  
- I understand that ONLY a complete uniform is acceptable for this class.
  
- I understand that ONLY approved program uniform attire can be worn while in class, outside of class on breaks or class functions, during my hospital and ambulance rotations, during Open Lab and any other class related function where the uniform is appropriate.
  
- I understand that I may be asked to leave class if I am not in the correct uniform and that I will not be given credit for the day's hours.
  
- I understand that a uniform being cleaned or laundered is not an acceptable reason to be out of uniform.
  
- I understand and agree to all terms of the West Los Angeles College EMT Uniform Agreement.

Student's Printed Name: \_\_\_\_\_

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## EMT Course Commitment

I, \_\_\_\_\_, (print Full Name) have received, read, and understand the requirements for this course. I am committing my effort to be successful in this program by agreeing and understanding the following:

\_\_\_ I have read, understand, and agree to adhere the points outlined in the course syllabus.

\_\_\_ I understand that I am responsible for all the material in the textbook and skills workbook, some of which may not be discussed in class. I recognize that I will be required to study material on my own in order to gain all the information necessary to pass this class.

\_\_\_ I agree to conduct myself in a professional manner while in class, on campus, in the field, and any other time I am in uniform representing West Los Angeles College.

\_\_\_ I have read and understand the Los Angeles County Department of Health Emergency Medical Services Agency (REF No. 1301), "Code of Ethics," which defines ethical responsibilities as practicing Respect, Caring, Fairness, and Integrity.

\_\_\_ I understand and agree that cheating and/or professional misconduct of any kind will not be tolerated and may result in the immediate dismissal from the program.

\_\_\_ I understand and agree that if I am unable to maintain the minimum scores required for certification I may be removed from the program.

I have read and fully understand the conditions and requirements set forth in the EMT course policies. Furthermore, I agree to be bound by this statement for the entire duration of my enrollment in the West Los Angeles EMT Program.

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

## EMT Student Physical Clearance Attestation

**Student Name (PRINT):** \_\_\_\_\_ **Student Phone #:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Student ID #:** \_\_\_\_\_

This course is a physically demanding class and profession. Students must be in good physical condition to handle the demands of this course. By signing this form, you confirm your ability to participate in the course without limitation. The physical requirement of the course requires students to demonstrate a high degree of manual dexterity, physical flexibility, and have the ability to perform repetitive tasks. Students should also have the ability to perform the following:

- Lift and move patients on and off the gurney with assistance of other
- Carry standard equipment used in in prehospital setting, may weigh up to 30 pounds
- Walk reasonable distances (up to several miles a day)
- Reach above shoulder level
- Hear and speak clearly on a telephone
- Work with chemicals and detergents
- Tolerate exposures to dust and/or fumes
- Perform CPR
- Bend down using legs
- Kneel down
- Grip equipment and/or gurney
- Sit for extended periods of time
- Stand for extended periods of time
- Distinguish colors

**Students Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# EMT Personal Protective Equipment (PPE) Training

I, \_\_\_\_\_, (print Full Name) have completed training in proper use, donning, and removal of gloves, eye protection, and gowns while using aseptic techniques.

Furthermore, I have received, read, and understand the following Los Angeles County Department of Health Emergency Medical Services Agency references:

- Treatment Protocol for Potential COVID-19 patients (REF. No 1245)
- Treat and Refer for Mild Respiratory Illness During the COVID-19 Outbreak (REF. No 845)
- Communicable Disease Exposure and Testing (REF. No 836)
- Communicable Disease Exposure Notification Report Form (REF. No 836.2)

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

## **EMT Background and Criminal History Training**

I, \_\_\_\_\_, (print Full Name) have received, read, and understand the following Los Angeles County Department of Health Emergency Medical Services Agency and National Registry of EMTs (NREMT) references:

1. EMT FAQ – Background
2. Criminal Convictions – NREMT Policy No. 81.05

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

# Certification/License Action Criteria

## CCR section 100214.3 (c)

Which criminal offenses **SHALL** exclude an applicant from being eligible for EMT Certification?

Lifetime

1. Has been convicted of any sexually related offense specified under Section 290 of the Penal Code
2. Has been convicted of murder, attempted murder, or murder for hire
3. Has been convicted of two (2) or more felonies
4. Is on parole or probation for any felony
5. Has been convicted and released from incarceration for offenses during the preceding fifteen (15) years for the crime of manslaughter or involuntary manslaughter
6. Has been convicted and released from incarceration during the preceding ten (10) years for any offense punishable as a felony
7. Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to the use, sales, possession, or transportation of narcotics or addictive or dangerous drugs.
8. Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to force, threat, violence, or intimidation
9. Has been convicted within the preceding five (5) years of any theft related misdemeanor

May be certified/licensed after the time frame is completed

Which criminal offenses **MAY** exclude an applicant from being eligible for EMT Certification?

1. Has committed any act involving fraud, intentional dishonesty for personal gain within the preceding seven (7) years
2. Is required to register pursuant to Section 11590 (Controlled Substance Offender) of the Health and Safety Code

By signing below I acknowledge that I have fully read and understand the criteria for potential disqualification for certification/licensure. I understand that if I have any questions or concerns about the criteria, it is my responsibility to discuss with the instructor.

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

## Health and Safety Code Violations 1798.200 (c)

Any of the following actions shall be considered evidence of a threat to public health and safety **and may result in denial, suspension, or revocation of a certificate or license, or in the placement on probation of a certificate or license holder under this division:**

1. Fraud in the procurement of any certificate or license.
2. Gross negligence.
3. Repeated negligent acts.
4. Incompetence.
5. The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of prehospital personnel.
6. Conviction of any crime that is substantially related to the qualifications, functions, and duties of prehospital personnel. The record of conviction or a certified copy of the record of conviction shall be considered conclusive evidence of the conviction.
7. Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel.
8. Violating or attempting to violate any federal or state statute or regulation that regulates narcotics, dangerous drugs, or controlled substances.
9. Addiction to, the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.
10. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification.
11. Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired
12. Unprofessional conduct exhibited by any of the followings:
  - Mistreatment or physical abuse of any patient resulting from excess force in excess of what a reasonable and prudent person trained in a similar capacity would use
  - Failure to maintain confidentiality
  - The commission of any sexually related offense under Section 290 PC

By signing below I acknowledge that I have fully read and understand the criteria for potential disqualification for certification/licensure. I understand that if I have any questions or concerns about the criteria, it is my responsibility to discuss with the instructor.

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

## Intent

The intent of this policy is to establish eligibility requirements for National Certification related to criminal convictions.

## Scope

This applies to eligibility requirements for initial and continuing certification by the National Registry.

## Definitions

Conviction – an applicant's plea of nolo contendere, a guilty plea, or plea agreement, as well as a conviction after trial

## Policy

1. The National Registry may deny an applicant eligibility to sit for a certification examination, deny certification, suspend or revoke an individual's certification, or take other appropriate action with respect to the applicant's certification or recertification based on an applicant's felony criminal convictions and all other criminal convictions (whether felony or misdemeanor) relating to crimes involving physical assault, use of a dangerous weapon, sexual abuse or assault, abuse of children, the elderly or infirm and crimes against property, including robbery, burglary and felony theft.
2. All applicants for certification or recertification must disclose any criminal conviction as required on an application.
3. This policy applies to an applicant's plea of nolo contendere, a guilty plea, or plea agreement, as well as a conviction after trial.
4. Applicants are not required to disclose any criminal conviction that has been expunged from the public record or a deferred adjudication that did not result in the entry of a conviction judgment.
5. Failure to disclose a covered criminal conviction or the withholding of any material information regarding such conviction shall be an independent basis for denial of eligibility to sit for a certification examination, revocation of a certification or denial of an application for recertification.
6. National Registry shall advise licensing authorities of the availability of information related to disclosure of convictions.
7. National Registry may deny an applicant eligibility to sit for the certification examination, or take other appropriate action, if the applicable state licensing authority, in any state in which the applicant holds or seeks a license as an EMS professional, denies the applicant's eligibility to obtain, or suspends or revokes, authorization to practice, based on a criminal conviction.

By signing below I acknowledge that I have fully read and understand the criteria for potential disqualification for certification/licensure. I understand that if I have any questions or concerns about the criteria, it is my responsibility to discuss with the instructor.

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

<b>National Registry of Emergency Medical Technicians®</b> <small>THE NATION'S EMS CERTIFICATION™</small>	<h1>Criminal Convictions</h1>		
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8. Notwithstanding the absence of any adverse action taken by an applicable state licensing authority on the basis of an applicant’s criminal conviction, National Registry may deny an applicant eligibility to sit for a certification examination or recertification if, in the National Registry’s sole discretion, based on the following considerations, the National Registry determines that certification may jeopardize public health and safety:
  - a. The seriousness of the crime.
  - b. Whether the crime relates to performance of the duties of an EMS professional.
  - c. How much time has elapsed since the crime was committed.
  - d. Whether the crime involved violence to, or abuse of, another person.
  - e. Whether the crime involved a minor or a person of diminished capacity.
  - f. Whether the applicant's actions and conduct since the crime occurred are consistent with the holding of a position of public trust.
  - g. Whether the applicant is a repeat offender.
  - h. Whether the applicant has complied with all court orders and probationary requirements associated with the conviction.

Any applicant or registrant subject to an adverse decision by the National Registry under this Policy may appeal that decision as outlined in the National Registry Certification Eligibility, Discipline and Appeals Policy.

### Rationale

The National Registry of Emergency Medical Technicians (National Registry) has adopted a Criminal Conviction Policy to safeguard the public from individuals who, in practice as an EMS professional, might pose a danger to the public.

EMS professionals, under the authority of their state authorization to practice, have unsupervised, intimate, physical and emotional contact with patients at a time of maximum physical and emotional vulnerability, as well as unsupervised access to a patient’s personal property. These patients may be unable to defend or protect themselves, voice objections to particular actions, or provide accurate accounts of events at a later time. EMS professionals, therefore, are placed in a position of the highest public trust.

The public in need of out-of-hospital medical services relies on state authorization to practice and national certification to assure that those EMS professionals who respond to their calls for aid qualify for this extraordinary trust. For these reasons, the National Registry has adopted this Criminal Conviction Policy to ensure that individuals, who have been convicted of certain crimes, are identified and appropriately evaluated as to whether they would pose a risk to public safety as an EMS provider.

By signing below I acknowledge that I have fully read and understand the criteria for potential disqualification for certification/licensure. I understand that if I have any questions or concerns about the criteria, it is my responsibility to discuss with the instructor.

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

VERIFY REVISION STATUS OF DOCUMENTS BEFORE USING

<b>National Registry of Emergency Medical Technicians®</b> <small>THE NATION'S EMS CERTIFICATION™</small>	<h1>Criminal Convictions</h1>		
Policy No.: 81.05	Revision: 01	Effective: November 14, 2018	Page <b>3</b> of <b>3</b>

**Related Policies and Procedures**

Terms of Certification

**References**

None

**Document History**

- 2017-05-19    Created and approved
- 2018-11-14    Approved by the NREMT Board of Directors

By signing below I acknowledge that I have fully read and understand the criteria for potential disqualification for certification/licensure. I understand that if I have any questions or concerns about the criteria, it is my responsibility to discuss with the instructor.

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

VERIFY REVISION STATUS OF DOCUMENTS BEFORE USING

# Emergency Contacts

Student's Name: \_\_\_\_\_

Student's Address: \_\_\_\_\_

Student's Cell Phone Number: \_\_\_\_\_

Student's Email Address: \_\_\_\_\_

Current Medications: \_\_\_\_\_

List of Allergies: \_\_\_\_\_

Doctor's Name and Phone Number: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Parent/Guardian's Phone Number: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Alternate Contact Name: \_\_\_\_\_

Alternate Contact Phone Number: \_\_\_\_\_

Notes:

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# PHOTOGRAPHY / VIDEO / FILM RELEASE FORM

I hereby grant West Los Angeles College the irrevocable and unrestricted right to use and publish photographs/video/film of me, or in which I may be included, for college publications, electronic reproductions (web site) and/or promotional materials or any other purpose and any manner or medium of usage. In addition, I grant permission to alter the same without restriction; and to copyright the same. I hereby release the photographer/camera operator and West Los Angeles College from all claims and liability relating to said photographs/video/film.

\*If the subject is a minor, parent or legal guardian must sign.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

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

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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## Declination

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I hereby **DO NOT** grant West Los Angeles College the irrevocable and unrestricted right to use and publish photographs/video/film of me, or in which I may be included, for college publications, electronic reproductions (web site) and/or promotional materials or any other purpose and any manner or medium of usage.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

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

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_



## Exhibit A Student Intern Agreement and Release

Student is enrolled in a course of study at **Insert Name of School** ("School") designed to enable Student become a licensed/certified Emergency Medical Technician, Paramedic or other similar pre-hospital health care provider. As part of the curriculum, Student has enrolled in the Clinical Experience, which is offered through the School, with Company's assistance. The Clinical Experience involves: 1) Student's performing acquired pre-hospital skills alongside Company's personnel; and, 2) accompanying and observing the Company's personnel providing emergency and non-emergency ambulance transport, care and related services.

Student has asked to participate in Clinical Experience knowing that participation will require Student to accompany Company personnel in dangerous and potentially life threatening situations. Student realizes that Company could not, and would not, allow Student to accompany its personnel without his/her agreement to: (i) release the company from any and all claims for injury or death which may result from Student's participation in the program; (ii) assume the risk of death or injury associated with the Clinical Experience; (iii) agree to read, understand and follow Company's policies, procedures and guidelines; (iv) act in a professional and respectable manner at all times; and follow the instruction/direction of Company personnel with respect to patient care, demeanor, safety, use of personal protective devices, scene control, etc.

Student understands that he or she is exposing himself or herself to certain risks inherent in the activities associated with the Clinical Experience. Student hereby represents that he or she **AGREES TO ASSUME THE RISKS INHERENT IN THE ACTIVITY**. These risks include, but are not limited to, being hurt or injured: (1) by broken glass (or other scene hazards) including various cuts about the head, face, eyes, hands, legs, and torso; (2) by exposure to tetanus or contagious diseases such as the Hepatitis B virus and the Human Immunodeficiency Virus ("HIV"); (3) injury due to gurney lifts and or drops; (4) injury from slip and fall type incidents; (5) various strains and/or sprains to one and/or all muscle groups; (6) risks associated with emergency vehicle operation; and (7) risks at the scene of emergencies including assault and battery.

In consideration of Company's agreement to provide the Clinical Experience to Student, Student agrees to release and forever discharge Company and its agents, employees affiliates, parent corporation, successors and assigns of and from all claims, demands, suits, injuries or damages of any kind arising in any way out of the participation in this program.

Student further agrees to: (i) follow Company's policies, procedures and work rules; (ii) follow Company's instruction and direction with respect to patient care, safety, personal protection; and, abide by Company rules and direction. Student understands that failure to follow the Company's direction may result, in Company's sole discretion, in his/her expulsion from the Clinical Experience program.

The School shall require its students to complete a Criminal Offenders Record Information ("CORI") check. By virtue of this agreement, the School assures AMR that it found no information that would, in accordance with the provisions of state EMS regulations, preclude the Student from the duties of an EMS provider.

The relationship of field internship Student and AMR is that of a student being provided an educational experience by AMR and such activity shall in no way be construed as creating any other relationship including an employment relationship. The Student shall receive no compensation from AMR for activities during the internship.



AMR has made available to the Student a copy of its Code of Conduct, Anti-kickback policies and other compliance policies, as may be changed from time-to-time, at AMR's web site, located at: [www.amr.net](http://www.amr.net), and the Student acknowledges receipt of such documents. AMR warrants that its personnel shall comply with AMR's compliance policies, including training related to the Anti-kickback Statute

The Student represents and certifies that he/she has not been convicted of any conduct identified on Schedule "A". The Student further represents and certifies that he/she is not ineligible to participate in Federal health care programs or in any other state or federal government payment program, as provided on Schedule A or otherwise. The Student understands that if DHHS or OIG excludes he/she, from participation in Federal health care programs, he/she party must notify the other party within 5 days of knowledge of such fact, and the AMR may immediately terminate the Agreement.

Student certifies that he/she is at least eighteen (18) years old and is an adult with full legal authority to execute this release.

**By Signing this Document You Acknowledge That You Have Been Advised That There Are Risks Inherent in this Type of Activity and Have Decided to Assume That Risk and Release the Company of and from All Liability. You Agree to Release the Company from Any Claims Associated with the Event and That You, Not the Company, Are Assuming Complete and Total Responsibility for and Any and All Injuries, Damages or Losses That You May Suffer as a Result of Participating in the Clinical Experience Program.**

**I agree to all terms set forth above.**

Dated: \_\_\_\_\_

Signature of Student: \_\_\_\_\_

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



Health Insurance Portability and Accountability Act of 1996 (HIPAA)

WESTMED/MCCORMICK Ambulance service is committed to protecting our employees, the patients we serve and the company from illegal or damaging actions by individuals and the improper release of protected health information and other confidential or proprietary information.

Given the nature of our work, it is imperative that we maintain the confidence of patient information that we receive in the course of our work. WESTMED/MCCORMICK Ambulance Service prohibits the release of any patient information to anyone outside the organization unless required for purposes of treatment, payment or health care operations. Discussions of "Protected Health Information" (PHI) within the organization should be limited to, exchange of patient information needed for the treatment of the patient, billing and other essential health care operations, peer review, internal audits and quality assurance activities.

I recognize that unauthorized release of confidential information may make me subject to a civil action under the provisions of the Welfare and Institutions Code. I hereby agree not to divulge any information or records concerning any client/patient without prior authorization in accordance with the "Health Insurance Portability and Accountability Act" of 1996 (HIPAA) and WESTMED/MCCORMICK ambulance policy 2015.3.

STUDENT NAME: \_\_\_\_\_

SIGNATURE & DATE: \_\_\_\_\_

# Seasonal Influenza

## Declination Form

I, \_\_\_\_\_, (print Full Name) understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring seasonal influenza. I have been given the opportunity to be vaccinated against this infection at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at increased risk of acquiring influenza. If, during the season for which the CDC recommends administration of the influenza vaccine, I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination at no charge to me.

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

# Hepatitis B Virus (HBV)

## Declination Form

I, \_\_\_\_\_, (print Full Name) understand that due to my occupational exposure to blood and other potentially infectious materials, I may be at a risk of acquiring Hepatitis B Virus (HBV) infections. I have been given the recommendation to be vaccinated with Hepatitis B vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

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

## COVID-19 Vaccination

We are asking for dates of the vaccination to help determine when each student is considered fully vaccinated. When completing this form, do not provide any medical information, or any other information related to why you may not have received the COVID-19 vaccine. Simply fill in your name, check the appropriate box, sign, and date. If your situation changes in the future, please provide an updated attestation then. ***If you wish to decline the vaccination, only complete the bottom portion of this document.***

Please provide copies of vaccination card with this form.

Full Name: \_\_\_\_\_ Check which brand you received:  
 Pfizer     Moderna     Johnson & Johnson

1<sup>st</sup> dose of COVID-19 vaccine on: \_\_\_\_\_  
(MM/DD/YYYY)

2<sup>nd</sup> dose of COVID-19 vaccine on: \_\_\_\_\_ (if J&J received for 1<sup>st</sup>, enter N/A)  
(MM/DD/YYYY)

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

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## Declination Form

I, \_\_\_\_\_, (print Full Name) understand that due to my occupational exposure to blood, reparatory droplets, and other potentially infectious materials, I may be at a risk of acquiring COVID-19 virus. I have been given the recommendation to be vaccinated. However, I decline the COVID-19 vaccination at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring COVID-19.

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