

Application Checklist

Student Name _____ Course Name _____

Please turn in all these documents at one time, prior to the course start date. **All items must be turned in for you to be present in the classroom.** Here is the checklist for all EMS Courses:

- Application Packet (Page 1-15 is Mandatory)
- Background Check Authorization (Application Packet page 3)
- Enrollment Agreement (Application Packet page 4-6)
- Privacy Policy Acknowledgment (Application Packet page 10)
- Release of Records (Application Packet page 11)
- AMR Affiliation Agreement (Application Packet page 12-13)
- Hold Harmless Agreement (Application Packet page 14)
- Complete Immunization Passport (Application Packet page 15)

Submit Copies of Your:

- Driver's License
- High School/GED/College Diploma or Transcript
- American Heart Association BLS Card (*not needed for EMT In-Person Course*)
- State EMS License or NREMT Certificate (*not needed for EMT In-Person or EMT Online Courses*)

Turn in complete application paperwork in person or through email:

Providence Health Training
1313 N Atlantic Ste 4900
Spokane, WA 99201
Healthtraining.wa@providence.org

Call 509-473-6007 with any Questions.

Please submit full application to:

Providence
1313 N Atlantic, Suite 4900
Spokane, WA 99201
healthtraining.wa@providence.org

Demographic Information

First Name _____ Last Name _____ MI _____
Address _____ City _____ ST _____ Zip _____
Email _____ Birthdate _____
Driver's License Number /State _____ Expiration _____
Primary Phone _____ Alt Phone _____ Unisex Shirt Size _____

EMS Agency Data (If applicable)

EMS Agency Affiliation _____
Address _____ City _____ ST _____ Zip _____
Supervisor _____ Phone _____

Academic Performance

Please Sumit One of the Following	Year Complete	School
High School Diploma or GED		
College Degree		

EMT Certification (if applicable) _____ Year Complete _____ ST _____

I certify the above information is accurate and complete.

Signature of applicant

Date

Questions?
509-473-6007

Work Experience

(List relevant work experience you have had)

1. Organization	Dates Held
Address	
Position Held	Supervisor
Responsibilities	
2. Organization	Dates Held
Address	
Position Held	Supervisor
Responsibilities	
3. Organization	Dates Held
Address	
Position Held	Supervisor
Responsibilities	
4. Organization	Dates Held
Address	
Position Held	Supervisor
Responsibilities	

BACKGROUND CHECK AUTHORIZATION

Pursuant to the requirements set forth by governing entities, Providence must ask you to complete the following disclosure statement. This information will be kept confidential. Please answer fully and accurately. Note: Providence will confirm your answers to these questions by obtaining background checks and license verifications as applicable.

You will be notified of any resulting issues within two (2) business days after all reports are received. Providence will make a copy of the report available to you upon your request.

1. Have you lived outside the state of Washington? No _____ Yes _____
If yes, list all previous counties with their states where you have lived, or other countries: _____

2. Have you ever been convicted of a crime? No _____ Yes _____
If yes, please identify the offense(s), provide the date(s) of the conviction(s), the name of the court and the sentence(s) imposed: _____

3. Have you ever had findings made against you for domestic violence, abuse, sexual abuse, neglect, exploitation or financial exploitation of a child or vulnerable adult in any civil adjudicative proceeding? (Civil adjudicative proceeding includes judicial or administrative proceedings as well as findings by DSHS or the Department of Health that you have not administratively challenged or appealed). No _____ Yes _____
If yes, please identify the specific finding(s), which agency or court made the finding(s), the date(s) of the finding(s) and the penalty imposed: _____

4. Have you ever had findings made against you would exclude you from participation in Medicare, Medicaid and other Federal Health Care Programs? No _____ Yes _____
If yes, please identify the offense(s), provide the date(s) of the conviction(s) imposed: _____

Providence may request your fingerprints to obtain from the criminal identification systems a report of your record of criminal convictions for offenses against person, civil adjudications of child abuse, and disciplinary board final decision.

I declare under the penalty of perjury under the laws of the State of Washington that the foregoing is true and correct. I understand that if I am hired or allowed to participate in any of our programs/classes, I can be discharged for any misrepresentation or omission in the above statement. I also understand that if hired or allowed to participate in any of our programs/classes, my employment/acceptance into the program/class is conditioned on satisfactory results of all background checks.

I hereby authorize Providence to obtain background checks as applicable at any time during my time as a student.

Name (Print): _____ Date of Birth: _____

Alias/Maiden: _____ SSN: _____

Signature: _____ Date Signed: _____

Full Current Address: _____

Providence Health Training Program
1313 N Atlantic, Suite 4900
Spokane, WA 99201

This **Enrollment Agreement** is between the above-named school and:

Student Name: _____ Program: _____

TUITION AND PRICING:

Program	Tuition	Lab Fees	Book Fees	Total
NAC	\$815	\$140	\$45	\$1,000
EMT	\$1,219	\$100	\$325	\$1,644
Advanced EMT	\$1,290	\$180	\$420	\$1,890
Paramedic	\$11,880	\$650	\$1,350	\$13,880

COST AND PAYMENT:

Program cost breakdown is listed on attached registration documentation. Student agrees to payment of all fees as listed including the book and lab fees which are due at time of registration along with portion of tuition. Students will be invoiced after the start of class. Payments are due by the first day of the month by credit or debit card through the online payment portal or over the phone with a school representative. Checks are also an acceptable form of payment and can be mailed or delivered to the address above. Monthly payment amount will vary based on deposit and partial payments are acceptable. Balance must be paid in full prior to the end of the course except for the Paramedic program where payments can be made for 24 months. Failure to make monthly payments or pay the full tuition as agreed upon will result in termination from the program and accounts sent to a collection agency.

AGREEMENT NOTICE:

This agreement will be binding when it has been fully completed, signed, and dated by the student.

APPLICANT REPRESENTS THE FOLLOWING TO BE TRUE:

- I agree that my continuation in a Providence education program shall be contingent upon my meeting the requirements of the course of instruction which is set forth in the Policy Manual located at Providence.org/healthtraining under the vocational education tab.
- I agree that I may be dismissed from a Providence education program in accordance with the policies set forth in the Policy manual and will be responsible for all expenses as required by the Program.
- I will abide by the Uniform/Personal Appearance policy for students as outlined in the manual.
- My attendance in the program will authorize Providence to use my likeness for promotional materials without any form of compensation.
- I agree the consent for a background check form must be completed and will become a part of my student file.
- I understand that as a student in a Providence education program, I am not an agent or employee of Providence and will not represent myself as one at any time.
- Providence has the final authority to approve or decline all clinical and field sites for use by the students.
- I agree that the points mentioned in this Agreement, the Policy Manual, and the Program objectives are criteria for successful completion of the program and are not all-inclusive and may be added to, or changed, at the discretion of Providence, if such changes or additions are deemed necessary to improve the program.
- I agree that this document shall become a part of my student file, and that this shall become a binding agreement between Providence and me.

CHANGES TO AGREEMENT NOTICE:

Any changes in the agreement must be acknowledged in writing by an authorized representative of the school and by the student.

CANCELLATION AND REFUND POLICY:

1. The school must refund all tuition, book and lab paid if the applicant is not accepted. This includes instances where a starting class is cancelled by the school. This does not include any non-refundable application fees.
2. The school must refund all tuition monies paid if the applicant cancels within five business days after the day the contract is signed or an initial payment is made if training **has not** begun.
3. Monies paid for books and lab fees, which are due at the time of registration, are not part of tuition fees. Book and lab fees are non-refundable.
4. The school may retain an established registration fee equal to ten percent of the total tuition cost, or one hundred dollars, whichever is less, if the applicant cancels past the fifth business day after signing the contract or making an initial payment. A registration fee is any fee charged by a school to process student applications and establish a student record system.
5. If training is terminated after the student enters class the school may retain book and lab fees, the registration fee established under (4) of this subsection, plus a percentage of the total tuition as described in the following tables:

In Person Courses:

*If the student completes this amount of training:	School may keep this percentage of tuition:
Up to 10%	10%
11% - 24%	25%
25% - 49%	50%
50% or more	100%

*EMT/AEMT based on 3 months of training, Paramedic based on 12 months of training, and NAC based on 6 weeks of training all starting day 1 of class.

Hybrid Courses:

*If the student completes this amount of training:	School may keep this percentage of tuition:
Up to 1.5 weeks of studies equaling 10%	10%
1.6 to 6.5 weeks of studies equaling 11% - 24%	25%
6.6 to 7.4 weeks of studies equaling 25% - 49%	50%
More than 7.5 weeks of studies equaling 50% or more	100%

*EMT/AEMT based on 15 weeks of studies starting on the virtual orientation day 1.

When calculating refunds, the official date of a student’s termination is:

1. When the school receives notice **in writing** of the student’s intention to discontinue the training program; or,
2. When the student is terminated for a violation of a published school policy which provides for termination; or,
3. When a student, without notice, falls below a 90% attendance rate.

All refunds must be paid within thirty calendar days of the student’s official termination date.

CANCELLATION AND REFUND POLICY FOR VA STUDENTS Using the GI Bill® Only:

Providence agrees that if a veteran student fails to enter the course, withdraws, or is discontinued at any time prior to completion of the course, the unused portion of paid tuition, fees, and other charges will be refunded or the debt for such tuition, fees, and other charges will be canceled on a prorated basis, as follows:

Registration Fee - An established registration fee in an amount not to exceed \$10 need not be subject to proration. Where the established registration fee is more than \$10, the amount more than \$10 will be subject to proration.

CANCELLATION AND REFUND POLICY FOR VA STUDENTS Using the GI Bill® Only cont':**Books, Supplies, and Equipment**

The school will make a refund in full for the charge for unissued books, supplies, and equipment when:
The school furnishes the book, supplies, and equipment, and they are included in the total charge for the course.
The veteran or eligible person withdraws or is discontinued before completing the course.

Tuition and Other Charges - Where the school either has or adopts an established policy for the refund of the unused portion of tuition, fees, and other charges subject to proration, which is more favorable to the veteran or eligible person than the approximate prorated basis as provided in this subparagraph, such established policy will be applicable. Otherwise, the school may charge a sum which does not vary more than 10 percent from the exact pro rata portion of such tuition, fees, and other charges that the length of the completed portion of the course bears to its total length. The exact proration will be determined on the ratio of the number of days of instruction completed by the student to the total number of instructional days in the course.

Prompt Refund - In the event that the veteran, spouse, surviving spouse or child fails to enter the course, or withdraws, or is discontinued there from any time prior to completion of the course, the unused portion of the tuition, fees, and other charges paid by the individual shall be refunded promptly. Any institution which fails to forward any refund due within 30 days after such a change shall be deemed, prima facie, to have failed to make a prompt refund, as required by this subparagraph.

NOTICE TO BUYER:

Do not sign this agreement before you read it or if it contains any blank spaces. This is a legal instrument. All pages of this contract are binding. Read both sides of all pages before signing. You are entitled to an exact copy of the agreement, school catalog, and any other papers you may sign, and are required to sign a statement acknowledging receipt of those.

CANCELLATION OF CONTRACT:

If you have not started training, you may cancel this contract by submitting written notice of such cancellation to the school at its address shown on the contract. The notice must be postmarked no later than midnight of the fifth business day following your signing this contract; the written notice may also be personally or otherwise delivered to the school within that time. In event of dispute over timely notice, the burden to prove service rests on the applicant.

UNFAIR BUSINESS PRACTICES:

It is an unfair business practice for the school to sell, discount, or otherwise transfer this contract or promissory note without the signed written consent of the student or his/her financial sponsors if he/she is a minor, and a written statement notifying all parties that the cancellation and refund policy continues to apply.

CERTIFICATION:

I certify that I read and understand the cancellation and refund policy and the complaint procedure; I have access to a copy of the school policy manual, and I am entitled to an exact copy of this enrollment agreement, and any other papers I sign.

Student

Please print

Date

Signature

School Authorized Representative

Signature

Date

Attachment A

NOTICE OF FINANCIAL OBLIGATION

Washington law requires the following information to be supplied to each student enrolling in a private vocational school licensed under Chapter 28C.10 RCW. One copy of this notice bearing original signatures must be attached by the school as addenda to that individual's enrollment agreement, as well as a copy provided to the enrollee by the school.

ACKNOWLEDGMENT BY ENROLLEE

- I understand and accept that any contract for training I enter with the above-named school contains legally binding obligations and responsibilities.
- I understand and accept that repayment obligations will be placed upon me by financing arrangements I enter into as a means to pay for my training.
- I understand that any enrollment contract I sign will be binding and take effect after five business days, provided that I have not started classes.

I understand that if I did not pay for my course in full at the time of registration, then I must make payments monthly to stay enrolled in the course and full tuition, books and lab fees must be paid in full by the end of course. **Failure to make a monthly payment will result in termination from the program.**

Name: _____

Signature: _____

Date: _____

ACKNOWLEDGMENT BY SCHOOL

Prior to being enrolled in this school, the applicant whose name and signature appears above has been made aware of the legal obligations he/she takes on by entering a contract for training. Those discussions included cautions by the school about acquiring an excessive debt burden that might become difficult to repay given employment opportunities and average starting salaries in his/her chosen occupation.

Name: _____

Title: _____ Date: _____

Signature: _____

Attachment B

HOW TO FILE A COMPLAINT

Washington law requires private vocational schools to inform students how to file a complaint. By signing this form, you acknowledge this process has been explained to you. Below are the next steps the school must take in discussing this policy with you, along with information about the complaint process.

DISCUSSION ABOUT COMPLAINT POLICY REQUIRED

First, a school representative must discuss the school's complaint policy with you. Following this discussion, you will be provided with this attachment to sign. After you sign this form, the school will keep a copy in your student records, and you will have access to a copy of the signed form at any time.

ACKNOWLEDGMENT OF COMPLAINT PROCESS BY STUDENT

- The school has described the grievance and/or complaint policy to me.
- I understand that the policy can also be found in the school policy manual.
- I know I should first try to resolve a complaint or concern with my instructor or school administrator.
- I understand nothing prevents me from contacting the Workforce Board at 360-709-4600 at any time with a concern or complaint, and complaint forms are: http://wtb.wa.gov/PCS_Complaints.asp.
- I understand that I have one year to file a complaint from my last date of attendance.
- I further understand that in the event of a school closure, I have 60 days to file a complaint.
- I also understand that complaints are public records.
- Finally, I acknowledge that details about the complaint process, my rights, and any restrictions on the time I have to file a complaint can be found at http://wtb.wa.gov/PCS_Complaints.asp

Name: _____

Signature: _____

Date _____

ACKNOWLEDGMENT BY SCHOOL

Name: _____

Title: _____ Date _____

Signature: _____

This school is licensed under Chapter 28C.10 RCW.

Inquiries or complaints regarding this private vocational school may be made to:

Workforce Training and Education Coordinating Board

128 10th Avenue SW

Olympia, Washington 98501

Phone: 360-709-4600

Email: pvs@wtb.wa.gov

Web: wtb.wa.gov

In compliance with the Workforce Training and Education Eligible Training Provider/Private Career School Annual Date Report, Providence is asking all students to voluntarily provide the following information. Data collected does not become public record. Individually identifiable information received by the Workforce Training and Education Coordinating Board for research or evaluation purposes are not subject to public disclosure under RCW 42.17.

Student Data

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Social Security #: _____ Date of Birth: _____

Hispanic

Indicate whether the student is Hispanic (a person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race).

_____ Hispanic Origin _____ Not of Hispanic Origin _____ Unknown

Race

- | | |
|---|---|
| _____ White/Caucasian | _____ Hawaiian Native or other Pacific Islander |
| _____ Black/African American | _____ Multi-racial |
| _____ American Indian or Alaskan Native | _____ Other |
| _____ Asian | _____ Unknown |

Gender

_____ Male _____ Female _____ Unknown

Disability

Defined as a physical or mental impairment which substantially limits one or more major life activities, such as seeing, hearing, speaking, walking, learning, and working.

_____ Yes _____ No _____ Unknown

Veteran Status

Student served, but is not currently serving, on active duty in the U.S. Army, Navy, Air Force, Marine Corps, or the Coast Guard.

_____ Yes _____ No _____ Unknown

Prior Education – before enrolling in program

- | | |
|---|--------------------------------|
| _____ Less than high school diploma | _____ Bachelor's Degree |
| _____ GED | _____ Master's Degree |
| _____ High school graduate | _____ Doctoral Degree or above |
| _____ Some post high school, no degree or certificate | _____ Other |
| _____ Certificate (less than two years) | _____ Unknown |
| _____ Associate degree | |

Privacy Policy Acknowledgement

I acknowledge that I have read, understand, and agree to comply with the Providence policies regarding the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”). I also understand that all protected health information (“PHI”) such as patients’ medical records (i.e., admitting/discharge records, labs, imaging), confidential information (i.e., social security number, financial information, card holder data), and other data to which I have knowledge of and/or access to as a result of being a student in the program will be kept confidential. I agree not disclose this information under any circumstances including to family, friends, and/or social media sites (i.e., Facebook, Twitter, etc.).

I acknowledge that I must de-identify all patient data that I obtain in a clinical setting so I can use it as part of my participation in the Providence education program including uploading it into Platinum Planner. De-identification specifically requires removal of identifiers of the patient or of relatives, employers, or household members of the patient. More specifically, the following identifiers must be removed:

(A) Names	(J) Account numbers
(B) All geographic subdivisions (street address, city, county, zip code)	(K) Certificate/license numbers
(C) All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age	(L) Vehicle identifiers and serial numbers, including license plate numbers
(D) Telephone numbers	(M) Device identifiers and serial numbers
(E) Fax numbers	(N) Web Universal Resource Locators (URLs)
(F) Email addresses	(O) Internet Protocol (IP) addresses
(G) Social security numbers	(P) Biometric identifiers, including finger and voice prints
(H) Medical record numbers	(Q) Full-face photographs and any comparable images
(I) Health plan beneficiary numbers	(R) Any other unique identifying number, characteristic, or code
<u>And:</u> The covered entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.	

I understand that I cannot remove any confidential data/information including PHI from a clinical setting (i.e., hospital, EMS agency, clinic, etc.) where I may be assigned as part of my Providence educational experience. I also agree to become knowledgeable of the assigned clinical setting privacy/security policies and follow them. I agree that any clinical data that I have access to and may be needed to demonstrate clinical competency as part of my Providence education course requirements will be de-identified. I understand that it is never acceptable to disclose any confidential information including posting such information in social media (i.e., Facebook, Twitter) and/or public settings. I also agree not to send confidential information including PHI to my private email account or download it on my personal computer and/or mobile device. I understand that if I breach this Confidentiality Agreement, Providence may institute disciplinary action up to and including expulsion from the program without refund.

Print Name _____ Date _____

Signature of Student _____

Authorization to Release Student Records

To: Providence Health Training

Please release my educational records to the following person(s) or Agency

Only type of information that is to be released under this consent is:

- Transcript
- Disciplinary records
- Recommendations for employment or admission to other schools
- Payment records
- Detailed educational records including test scores or educational progress.
- Other _____

The information is to be released for the following purposes:

- Communication about the students experience with Providence.
- Employment
- Admission to an educational institution
- Third party payors
- Other _____

I understand the information may be released orally or in the form of copies of written records, as preferred by the requestor. I have the right to inspect any written records released pursuant to this consent. I understand that I may revoke this consent upon providing emailed or written notice to Providence at healthtraining.wa@providence.org. I further understand that until this revocation is made, this consent shall remain in effect and my educational records may be released as approved above.

Name (print) _____

Signature _____



Exhibit A
Student Intern Agreement and Release

Student is enrolled in a course of study at **Providence** ("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. 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: _____

Hold Harmless Agreement

This document covers all EMS training programs including all lab, clinical and field activities.

I understand that this training will require hands-on participation on my part. I am physically fit to perform the duties of an EMS provider and not under a doctor's supervision for any physical condition that would excuse me from this training.

1. To participate in Providence Health Training activities and programs ("individually", "Program" and collectively, "Programs"), I release, waive, discharge and covenant not to sue any of the Providence Ministries, its Board of Trustees, officers, administrators, agents, or employees (hereinafter referred to collectively as "Indemnites"), from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by me, or to any property belonging to me, whether caused by the negligence or otherwise, while participating in such Programs, or while in, on or upon the premises where the Programs are being conducted.
2. I am fully aware of the risks and hazards connected with the Programs. I elect to voluntarily participate in the Programs, and to engage in such Programs knowing that the Programs may be hazardous to me and my property. I voluntarily assume full responsibility for any risks of loss, property damage or personal injury, including death, that may be sustained by me, or any loss or damage to property owned by me, because of being engaged in such Programs, whether caused by the negligence of the Indemnities or otherwise.
3. In signing this Waiver of Liability and Hold Harmless Agreement, I acknowledge and represent that I have read this document, understand it and sign it voluntarily as my own free act and deed; no oral presentations, statements, or inducements, apart from this Waiver of Liability and Hold Harmless Agreement, have been made.

Student Signature _____

Printed Name of Participant _____

Date _____

Immunization Passport

Name _____

Course: ___Paramedic ___ EMT ___AEMT ___NAC Course Start Date: _____

Please provide **appropriate medical documentation** for the following vaccinations:

___ TB Skin Test that was completed within the past year.

___ Measles, Mumps, Rubella – MMR (2-part series or immunity confirmed by Titer)

___ Varicella – Chicken Pox (2-part series or immunity confirmed by Titer)

___ Tetanus, Diphtheria, Pertussis- Tdap (must be within the last 10 years)

___ Hepatitis B (3-part series or immunity confirmed by Titer)

* Declination forms are available. Please note that not all agencies will accept declination.

___ Covid-19 (must include the manufacturer and date of administration)

*Declination forms are available. Please note that not all agencies will accept declination.

The documentation will be kept in your student file. If needed this documentation will be shared with our auxiliary sites as part of your education, including clinical sites and field internship sites. Vaccinations are required as part of Providence's clinical agreements with our auxiliary sites. Without proper documentation, Providence is not allowed to place any student in a clinical shift (hospital site) or field shift (EMS Agency site).

***Vaccine Declination Form-**

You have the option to decline one or both of these vaccines. *This form is not required if you choose to get the vaccines.* No other vaccine declination or exemptions are allowed due to our contractual requirements with our partner agencies. By declining either of these vaccines, you may be limiting the agencies where you are allowed to complete clinical or field internship rotations.

Hep B Series

Due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. I understand that I may change my mind at any time, get the Hep B vaccine series, and withdraw this declination form.

I understand and still decline.

Signature _____ Date _____

Covid-19 Vaccine

My school recommends that I receive COVID-19 vaccination to protect myself, patients, and staff. Due to my exposure to potentially high-risk patients, I may be at risk of acquiring a Coronavirus (COVID-19) infection. I have been given the opportunity to be vaccinated with the COVID-19 vaccine, however, I decline vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring COVID-19, a serious contagious disease that can easily spread from person to person. I understand that vaccination is recommended for all healthcare workers to help prevent spreading the disease and to protect myself. I also understand that I may change my mind at any time, get the COVID-19 vaccine, and withdraw this declination form.

I understand and still decline.

Signature _____ Date _____