



1016 E. Montague Avenue
N. Charleston, SC 29405
Phone: 843-529-0977
Fax: 843-529-0460
Email: info@lowcountryems.com

Intermediate Student Paperwork Checklist

The following information and required documentation must be submitted to the Lowcountry Regional EMS Council prior to admission into the Intermediate Class.

Entrance Requirements:

- Must be at minimum a South Carolina EMT-Basic and certification must remain in effect throughout the intermediate course.
- Successful completion of the Health Occupations Basic Entrance Test (HOBET) with a minimum composite score of 42% and a minimum reading score of 42%.

The attached documents must be completed fully and all requested information must be provided:

- Copy of South Carolina EMT or EMT-Intermediate certification wallet card
- Copy of a course completion card for Healthcare Provider Level CPR (either American Heart Association Basic Life Support, Red Cross Professional Rescuer or American Safety and Health Institute Professional Level CPR/AED) that is valid through the course exam date.
- Completed Health Statement Form (attached). The clinical contracts require that our office have on file for each student participating in the clinical process a current health statement verifying that the student has tested negative for tuberculosis within twelve (12) months of the beginning of the class and verifying immunization against Rubella, Rubeola, Varicella and Hepatitis B.
- Major Medical / Worker's Comp Documentation (attached). Each student must be covered by employers' Worker's Compensation or have major medical health insurance that remains in effect throughout intermediate training.

STUDENT NAME _____



1016 E. Montague Avenue
 N. Charleston, SC 29405
 Phone: 843-529-0977
 Fax: 843-529-0460
 Email: info@lowcountryems.com

STUDENT INFORMATION

Name _____
Last First Middle

Address _____
Street City State Zip

Telephone (____) _____ (____) _____ (____) _____
Home Work Mobile

In Case of Emergency Notify _____

Telephone (____) _____ (____) _____ _____
Home Work Relationship

HEALTH STATEMENT FOR INTERMEDIATE STUDENTS

To comply with the requirements of the affiliated hospital in which students conduct their clinical experiences, the following immunizations and health related items must be current. All information is to be verified by a physician, registered nurse or infection control officer. Military or other health records may be attached.

TB Skin Test ____/____/____ _____
Date Result Verified by Signature

- P.P.D. MUST BE NO MORE THAN TWELVE (12) MONTHS OLD -

Chest X-Ray (if applicable) ____/____/____ _____
Date Result Verified by Signature

Rubella/Rubeola (M.M.R.) ____/____/____ _____
Date Date Verified by Signature

Hepatitis B _____
Vaccine Date Begun Date Completed Verified by Signature

**Lowcountry Regional EMS Council
Varicella-Zoster (Chickenpox, Shingles) Screening Form**

For Intermediate Students Only – Not Valid for Paramedic Students

Student Name _____

Please read the following statements. Check as many as apply.

1. ___ I have proof of immunity in writing (documented immunization or titer results).
2. ___ I can report a reliable history of Varicella (Chickenpox) infection.
3. ___ I can report a reliable history of Herpes Zoster (Shingles) infection.
4. ___ I can report a reliable history of Vericella-Zoster immunization with two (2) doses of Varivax.
5. ___ A family member has a history of Varicella (Chickenpox). Relation _____.
6. ___ I do not know if I have had Varicella.
7. ___ I have not had Varicella illness or Varivax vaccination.

Please check the appropriate box and include your signature following that paragraph.

- I have verified immunization against Varicella-Zoster (Chickenpox, Shingles) as noted above.

Student Signature _____ Date ____/____/____

Witness _____ Date ____/____/____

- I have not verified immunization against Varicella-Zoster (Chickenpox, Shingles) as noted above; however, I have attached documentation of a titer screening documenting immunization against Varicella-Zoster (Chickenpox, Shingles).

Student Signature _____ Date ____/____/____

Witness _____ Date ____/____/____

- I have not verified immunization against Varicella-Zoster (Chickenpox, Shingles) as noted above. I understand that exposure to blood or other potentially infectious materials is likely during my clinical experience and I may be at risk of acquiring Varicella-Zoster (Chickenpox, Shingles). I have been advised to obtain vaccination against Varicella-Zoster (Chickenpox, Shingles), however I decline to seek vaccination at this time. I understand that by declining to seek this vaccination, I continue to be at risk of acquiring Varicella-Zoster (Chickenpox, Shingles), a serious disease.

Student Signature _____ Date ____/____/____

Witness _____ Date ____/____/____



1016 E. Montague Avenue
N. Charleston, SC 29405
Phone: 843-529-0977
Fax: 843-529-0460
Email: info@lowcountryems.com

EITHER major medical insurance **OR** Worker's Compensation coverage must be verified to allow participation in clinical training. The director of education must be informed immediately of any change in the status of this coverage.

Exhibit B

Major Medical Coverage Documentation

I understand that I am required to have major medical coverage (health and accident) in effect upon entering any allied health program. I am aware that I must maintain major medical coverage continuously while enrolled in any allied health program and that failure to do so will result in **DISMISSAL** from my program of study. I understand that I must keep the Program Coordinator informed of any changes in the policy information I have provided below.

Policy Number _____

Policy Effective Dates _____

Print Name _____

Carrier _____

Signature _____

Date _____

*Please Note: Any falsification of records will result in **DISMISSAL** from this program of study. Proof of major medical coverage may be required.

Worker's Compensation Coverage Documentation

I verify that the student listed below is covered by Worker's Compensation insurance while participating in training sponsored by the Lowcountry Region EMS Council. This coverage includes clinical training.

I understand that this coverage is required for participation in clinical training and will notify the Lowcountry Regional EMS Council of any change in the status of this coverage.

Student _____

Agency _____

Verifying Official _____

Date _____