

PASCO-HERNANDO COMMUNITY COLLEGE DIVISION OF HEALTH PROGRAMS

CERTIFICATE IN PARAMEDICS APPLICATION

Once you have met all of the program requirements for admission as listed in the application packet, you may submit this application to the Admissions and Student Records Office, West Campus/New Port Richey, by 4:00 pm on the deadline date. Prior to submitting this limited access application to the Admissions Office, pay the non-refundable \$25 application fee at any PHCC College Store.

Provide a clear copy of your Driver's License indicating a physical mailing address (PO Box addresses will not be accepted) and a clear copy of your Florida EMT license.

Name: _____
Last
First
Middle (required)

Previous Names: _____

Student ID Number: _____

Address: _____
Street

City
State
Zip

Phone Numbers: () _____ () _____ () _____
Home
Work
Other

APPLICANT CERTIFICATION: I CERTIFY THAT ALL STATEMENTS GIVEN IN THIS APPLICATION ARE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. ANY FALSIFIED INFORMATION MAY RESULT IN MY DISMISSAL FROM THE PROGRAM. I HAVE READ AND SUBMITTED THE INFORMATION ON THE ENCLOSED CHECKLIST REGARDING APPLICATION REQUIREMENTS, PREREQUISITES, SELECTION PROCEDURES, AND OTHER REQUIREMENTS CONCERNING THE PARAMEDIC PROGRAM AT PHCC.

SIGNATURE

DATE

FOR OFFICE USE ONLY			
<input type="checkbox"/> Checked by _____	Date _____	\$ _____	
	<input type="checkbox"/> Cash Receipt	No. _____	
	<input type="checkbox"/> Register Invoice	Cashier _____	

Paramedic - August

CERTIFICATE IN PARAMEDICS APPLICANT CURRENT EMT EMPLOYMENT VERIFICATION

Preference for admission will be given to those employed as EMTs in a fire department in Pasco or Hernando County and those who are residents of Pasco or Hernando County. If the attached copy of your Driver's License proves Pasco or Hernando County residence, this form is not required.

To verify such employment, the applicant needs to have the following information completed and submitted with this application.

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

Street

City

State

Zip

EMPLOYER'S STATEMENT:

I CERTIFY THAT _____ IS CURRENTLY
(Employee's Name)
EMPLOYED AS A LICENSED EMERGENCY MEDICAL TECHNICIAN AT THE AGENCY/COMPANY
NOTED ABOVE, WHICH IS LOCATED IN _____ COUNTY.

SUPERVISOR'S NAME: (please print) _____

SUPERVISOR'S SIGNATURE: _____

DATE OF EMPLOYMENT VERIFICATION: _____

SUPERVISOR'S PHONE NUMBER: _____

SUPERVISOR'S E-MAIL ADDRESS: _____