



Rice University Emergency Medical Services
Application and Paperwork Packet
Updated as of May 12th, 2014

This packet contains:

- Personnel Cover Sheet (fill out as much as possible)
- Duty Crew Application
- Observer Form
- Confidentiality Form
- VFIS Form (Volunteer Firemen's Insurance Services Form)
- Driving Release Form

In addition, copies of the following items are needed from all REMS applicants:

- NREMT card (required to schedule practical exam)
- TX DSHS EMT Certification card (required to become an official member)
- Healthcare Provider CPR card
- Driver's License
- Immunization records (current TB, Hep B, MMR, flu & chicken pox)
- Certificates for ICS 100, 200 & 700

Rice University EMS Personnel Cover Sheet

Name: _____ Rice ID: _____ Net ID: _____
 DL#: _____ State: ____ Expiration: _____ DOB: _____
 Local Address: _____ Shirt Size: _____
 Permanent Address: _____
 Cell: (____) _____ - _____ Emergency: (____) _____ - _____ College/Dept.: _____
 E-mail: _____ Year of Grad.: _____

	Expiration	Certification #
EMT-B (NREMT)		
EMT-B (DSHS)		
EMT-I /Advanced (NREMT)		
EMT-I /Advanced (DSHS)		
EMT-P (NREMT)		
EMT-P (DSHS)		
CPR		
CPR Instructor		

Annual tests	Date	Date	Date	Date	Date
TB Test					
HIPAA Test					
BBP Test					
Driving Release					

Paperwork:

- Duty Crew Application
- Observer Form
- Confidentiality Form
- VFIS Form
- Driving Release Form
- NREMT card
- TX DSHS EMT Certification card
- Healthcare Provider CPR card
- Driver's License
- Immunization records (current TB, Hep B, MMR, flu & chicken pox)
- Certificates for ICS 100, 200 & 700

Tests and Training:

- Observer Orientation
- Golf Cart Training
- HIPAA Test
- SOPs Test
- BBP Test
- Patient chart completed
- Practical Test

DC Cleared: _____ SE Cleared: _____
 ALS Cleared: _____ ICT Cleared: _____
 IC Cleared: _____ Preceptor Cleared: _____
 Disciplinary Action: _____

Notes: _____

File Opened: _____ File Archived: _____

CONFIDENTIAL

Rice Emergency Medical Services

Name: _____	Student ID: _____
Net ID: _____	Age: <u>Older than 18?</u> <u>Yes</u> <u>No</u>
Email: _____	Phone Number: _____
College: _____	Residence (on/off campus): _____
Expected Graduation: _____	Level: _____
TX DSHS Certificate Expiration: _____	NREMT Certificate Expiration: _____

Duty Crew Application

Rice EMS Member Responsibility Statement

Every member must understand Rice EMS is *not* a University club; rather, it is a state regulated department that offers a valuable service that affects the well-being of community members. Due to the profound responsibility held by each Rice EMT, higher standards are expected than those that apply to other University students. It is imperative to recognize that being involved in Rice EMS is a privilege, and in order to maintain an association with the department, an EMT must follow the following guidelines:

- Know and abide by the Rice EMS protocols and SOPs
- Attend all general membership meetings
- Practice and maintain his/her skills by doing at least 36 hours of ride time with an outside service every semester
- Work his/her scheduled shifts
- Find a replacement for any shift he/she is not able to work or fully complete
- Notify the scheduler AND the on-duty supervisor (if it is a same day schedule change) of any scheduling changes that are taking place
- Check the equipment and file an equipment report at the beginning of each shift
- File a missing/damaged equipment report if any equipment is missing or damaged and contact the on-duty supervisor
- Turn in all charts within 24 hours of any call

Each Rice EMS member is responsible for the above items. Maintaining knowledge, practicing skills, and following medical protocols are fundamental to providing an exceptional standard of care. Failure to comply with the responsibilities outlined above may result in probation, suspension, or expulsion from Rice EMS, alongside disciplinary measures outlined by the Texas Department of State Health Services and the Texas legal statutes.

In addition to the above requirements all REMS personnel need to send in/complete the following documents with their application:

Authorization: I authorize REMS to obtain information about me from previous employers and schools. I authorize disclosure of information to REMS from previous employers and schools

Accuracy: I verify that the statements I have made in this application are true and complete. I understand that false statements will be grounds for immediate discharge from REMS.

I verify that I am not now nor have I ever been excluded from any state or federal health care program. I understand that part of this application process *may* involve one or more of the following as deemed necessary by REMS: criminal background check, investigation of driving record and license status, drug and substance abuse test, and verification of any information contained in this application.

Name, Level

Signature

Date

1. Why do you want to be part of Rice EMS?

2. What experience do you have with other organizations? (Fire, Police, EMS) Do you currently (or are you planning to) volunteer/work for any outside EMS agencies? Please list any and all certifications you possess.

3. Where do you see yourself a year from now with Rice EMS? (i.e. applying to become an In-Charge, a college EMT, taking the intermediate class if you are a basic, etc.)

4. Why should you be selected to be a part of Rice EMS over the other people who are applying?

5. Do you have any outside regular commitments that will prevent you from being on duty during specific days (i.e. job, off-campus commitments, etc.) How many hours on average will you take per semester?

6. Have you even been convicted of a felony? (if yes, please explain)

7. Please list a personal reference we may be able to contact if necessary. If you know someone on REMS feel free to list him/her.

8. Have you ever taken a Citizen's Police Academy class or been part of a CERT (Crisis Emergency Response Team) team or any other such seminar?

9. Please list prior education and training experience. Did you graduate from High School? GED? College? Other School/Training?



Rice University EMS Observer Agreement Form

I _____ request to observe with Rice University Emergency Medical Services (REMS) from _____ to _____. I understand that the potential for serious injury or even death exists during the course of my observation time. By signing this release, I fully accept all liability for any injury sustained while observing with REMS. I furthermore release REMS and Rice University from any and all liability from the previously mentioned occurrences.

Briefly state your purpose for observing with REMS:

Contact Information

Address: _____ Over 18? _____ Yes _____ No _____

Phone Number: _____

Emergency Contact Name/Relationship/Phone Number: _____

Email: _____

Print full Name of Observer _____ Signature of Observer _____ Date _____

Print full Name of Witness _____ Signature of Witness _____ Date _____

REMS Supervisor Signature _____ REMS ID# _____ Date _____



Rice University EMS Patient Confidentiality Agreement

Patient health records contain sensitive personal information that is protected by confidentiality laws. As an EMT or Observer, I understand that I will have access to patient information through the course of my clinical experience, and I am prohibited from divulging or communicating this information at any time.

I agree to preserve the confidentiality of all clinical or patient information and to not divulge this information in any form, except where authorized by the patient or required by law. I may discuss patient encounters with in-charges, captain, director, medical director, or any agent that is mandated by law. However, the following restrictions apply:

- Patient identifiers (name, SSN, unique job, etc.) or any aspect of the case that could be used to identify the patient should not be discussed when identification is not necessary.
- Cases may not be discussed in common areas to include hallways, elevators, dining halls or other places where any part of the discussion could be overheard by non-authorized personnel.
- Cases should not be shared with family members, acquaintances, or anyone not formally involved in the educational program.

Any breach, on or off duty, of this agreement will be taken seriously. Any violation can or may result in legal or disciplinary action including from Rice University EMS or the State of Texas. I acknowledge that I have read the confidentiality agreement and understand my responsibilities as they pertain to confidentiality of personal information and agree to the principles of this agreement.

Student Signature: _____ Date: _____



Annual Medical Statement of Personnel

NOTE: This form is designed to provide the individual in charge of all personnel a complete history of physical status as of the date indicated without the need for expensive physical examinations. It is recommended that the form be completed on an annual basis by all drivers of emergency vehicles as well as other employees. If any of the questions are answered "YES," be sure the answer is fully explained.

Questions:

Name: _____
 Address: _____
 City & State: _____ Zip: _____
 Full Time Occupation: _____
 Name of Organization: _____
 Position/Title: _____
 Social Security No. _____
 What is your Valid State Operators Plate No. _____

REMARKS: If any question is answered, "YES," give particulars below. For medical histories, underline the item and identify by referring to question number and letter. Give dates, symptoms, duration, treatment results, names and addresses of doctors, hospitals, etc.

1. Birth Date: Month: _____ Day: _____ Year: _____

2. Eyesight:

	Yes	No
a. Have you lost use of either eye? _____ R _____ L.....a.	<input type="checkbox"/>	<input type="checkbox"/>
b. Is peripheral (side) vision restricted?b.	<input type="checkbox"/>	<input type="checkbox"/>
c. Are you color blind?c.	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you have, or have you ever had, cataracts?d.	<input type="checkbox"/>	<input type="checkbox"/>
e. Are actual deficiencies corrected by glasses or contact lenses? .e.	<input type="checkbox"/>	<input type="checkbox"/>
f. Date of last eye examination:f.		_____

3. Hearing:

a. Do you have difficulty hearing normal conversation level?a.	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you use a hearing aid?.....b.	<input type="checkbox"/>	<input type="checkbox"/>

4. Diabetes:

a. Have you ever been treated for diabetes?a.	<input type="checkbox"/>	<input type="checkbox"/>
b. Describe current medication and dosage, if any, and method of administration under "remarks."		
c. Date of latest blood sugar test:c.		_____

5. Heart:

a. Have you ever been treated for heart disease?a.	<input type="checkbox"/>	<input type="checkbox"/>
b. Describe condition:.....b.		
c. Describe current medication and dosage, if any, under "remarks."		
d. Do you have a pacemaker?.....d.	<input type="checkbox"/>	<input type="checkbox"/>
e. Date of last treatment or check-up:.....e.		_____

6. Epilepsy:

a. Have you ever been treated for epilepsy?a.	<input type="checkbox"/>	<input type="checkbox"/>
b. If "Yes," when was your last seizure?.....b.		
c. Describe current medication and dosage, if any, under "remarks."		

Questions:

REMARKS:

- 7. Blood Pressure:**
- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Have you ever been treated for high blood pressure?.....a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If "Yes," when were you treated?b. | _____ | |
| c. What was your last reading?c. | _____ | |
| d. Describe current medication and dosage, if any, under "remarks." | | |

- 8. Limbs:**
- | | | |
|--|--------------------------|--------------------------|
| a. Have you lost an arm or leg?.....a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you lost the use of an arm or leg?.....b. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Does vehicle have special controls?c. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If "Yes" to any of the above, describe under "remarks." | | |

- 9. Miscellaneous:**
- | | | |
|---|--------------------------|--------------------------|
| a. Have you ever had, or been treated for, Convulsions?a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| c. Have you ever had any Fainting Spells?c. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| e. Have you ever had, or been treated for, Loss of Equilibrium?.....e. | <input type="checkbox"/> | <input type="checkbox"/> |
| f. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| g. Have you ever been treated for Alcohol or Drug Abuse?g. | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| i. Have you ever been treated for Mental Illness?.....i. | <input type="checkbox"/> | <input type="checkbox"/> |
| j. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |

10. What is the date of your last physical examination?..... _____

11. Are there any restrictions posted on your vehicle operator's license?

12. Are you under the care of a physician for any condition not mentioned above which may affect your ability to operate a motor vehicle?

13. When and for what purpose, did you last consult a doctor?

14. Full Name, address and telephone number of your personal physician.

Name: _____

Address: _____

City & State: _____ **Zip:** _____

The answers to the above are complete, accurate, and true to the best of my knowledge.

Signature of Person Named Above

Date

Authorization For Release

"I hereby authorize any licensed physician, medical practitioner, hospital or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me or my health, to give _____ Department/Company any such information."

A photographic copy, Xerox copy or similar reproduction of this authorization shall be as valid as the original.

Signature of Person Named Above

Date

AUTHORIZATION TO RELEASE INFORMATION Motor
Vehicle Record Check

Under the provisions of the Fair Credit Reporting Act, 15 USC, Section 1681 et seq., the Americans with Disabilities Act and all applicable federal, state, and local laws, I hereby authorize and permit Rice University to obtain a consumer report and/or an investigative consumer report which may include the following:

Records concerning any driving, criminal history, credit history, and civil record.

I agree that a copy of this authorization has the same effect as an original.

I hereby release and hold harmless any person, firm, or entity that discloses matter in accordance with this authorization, as well as Rice University from liability that might otherwise result from the request for use of and/or disclosure of any or all of the foregoing information.

I understand and acknowledge that under provision of the Fair Credit Reporting Act I may request a copy of any consumer report from the consumer reporting agency that compiled the report, after I have provided proper identification.

I hereby authorize Rice University to obtain and prepare an investigative consumer report as set forth above. This authorization shall remain in effect over the course of my employment. Reports may be ordered periodically during the course of my affiliation with Rice.

Full Name _____

Date of Birth _____

Driver's License Number _____ Issuing State/Country _____

Signature _____

Date _____

*Please attach copy of Drivers License.