



# Good Fellowship Ambulance & EMS Training Institute

*Serving the Community for Over 50 Years*

600 Montgomery Avenue • PO Box 361 • West Chester, PA 19381-0361 • (610) 431-2303 • www.goodfellowship.com

## COURSE APPLICATION

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip+4: \_\_\_\_\_

County of Residence \_\_\_\_\_

SOC. SEC. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_\*

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-Mail: \_\_\_\_\_

**Education Level:** (check highest level completed)

High School Diploma/GED  Associates Degree  Bachelors Degree  Masters Degree

### **Certification Information:**

Certification #: \_\_\_\_\_ Issuing State: \_\_\_\_\_ Expiration: \_\_\_\_/\_\_\_\_/\_\_\_\_

NREMT#: \_\_\_\_\_ Type: \_\_\_\_\_ Expiration: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **Course of Enrollment:**

Emergency Medical Responder- \_\_\_\_\_ (Please place course number)

Emergency Medical Technician – \_\_\_\_\_ (Please place course number)

Advanced Emergency Medical Technician

AMLS EPC PHTLS EVOC EMS SAFETY: \_\_\_\_\_ (circle class and place date of class)

Please circle shirt size: Small Medium Large X-Large XX-Large XXX-Large

### **Affiliation:**

Primary EMS/FIRE/POLICE Affiliate: \_\_\_\_\_ Phone# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Affiliate Work Status:  Volunteer  Paid

### **Affiliate Authorization:**

I certify that \_\_\_\_\_ is representing and an active member of our organization. As the organization supervisor, I certify that the above student meets the prerequisites and age requirements to participate in this course. I further endorse the applicant's attendance in the \_\_\_\_\_ training program.

Signature of Officer: \_\_\_\_\_ Title: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Accommodation Information:**

Do you have any physical limitations, which preclude you from performing the skills established by the course curriculum?

No  Yes  If yes, describe: \_\_\_\_\_

**Criminal History**

Have you ever been arrested or convicted of a misdemeanor or felony? \*\* No  Yes

Specify charge or charges, dates and places: \_\_\_\_\_

**Affirmation**

I certify that the facts contained in this application are true and complete to the best of my knowledge, and I understand that if accepted, falsified statements on the application may be grounds for dismissal. I authorize investigation of all statements contained herein. I understand and agree that, if accepted, my enrollment may be terminated according to established course requirements.

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

\*Applicants must be at least 16 years of age prior to the start date of the training program.

\*\*Applicants will not be denied course attendance solely because of this information. For Dept. of Health courses only, if "Yes", the applicant must provide an original Pennsylvania State Police "Criminal Record Check". In some cases, the applicant will be required to provide additional documentation. A positive criminal history does not prevent anyone from enrolling in a training course, but may prevent ability for state certification. The Pennsylvania Department of Health will review individual registrations to determine eligibility for certification.

<b>DO NOT WRITE IN THIS SPACE (FOR OFFICE USE ONLY)</b>			
<b>Received on:</b> _____	<b>By: (initial)</b> _____		
<b>Reviewed by:</b> _____	<b>Date:</b> _____		
<b>Documentation of Review:</b> _____			
<b>Accepted:</b>	<b>Yes:</b> _____	<b>No:</b> _____	<b>Course Number:</b> _____

Once Application is completed, please fax to (610-840-0415), email to [training@goodfellowship.com](mailto:training@goodfellowship.com) or mail to:

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West Chester, PA 19381-0361**