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 Technician – Fall Spring Summer (Please circle which semester)
☐ ACLS PALS AMLS EPC AMLS ATT/ITLS EVOC
☐ NREMTP Refresher
☐ Other _____

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.

DO NOT WRITE IN THIS SPACE (FOR OFFICE USE ONLY)

Received on: _____ By: (initial)_____

Reviewed by: _____Date:_____

Documentation of Review:_____

Accepted: Yes: _____ No: _____ Course Number:_____