

Program Selection

Which program are you applying for?

- Primary Care Paramedicine (PCP)
- Advanced Care Paramedicine (ACP)
- Fulltime Program
- Extension Program

Note: For the PRAP and PRRP programs a referral letter must be supplied by Emergency Health Services of Nova Scotia for these programs outlining the requirements of the applicant.

Preferred Location: _____

- Provincial Reciprocity Attainment Program (PRAP)
- Provincial Refresher Registration Program (PRRP)

Paramedic Registration ACP, PRAP and PRRP applicants only

Province of Registration

Registration Level PCP (or equivalent)

Note: Applicants are required to provide proof of registration. This may be in the form of official provincial documentation or copies of Provincial ID Tag (Both sides)

ICP (or equivalent)

Years of Service

EMD

Continuing Education

	Provider	Instructor	Last Date Completed		Provider	Instructor	Last Date Completed
CPR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>	ACLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>
Emergency First Aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>	PALS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>
Standard First Aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>	PHTLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>
Advanced First Aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>	BTLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>
Marine First Aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>	NRP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>
Wilderness First Aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>	WHMIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>
First Responder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>

_____ Please indicate

Application Fee Non-Refundable

Refer to the application fee requirements in the Academic Calendar. Include the application fee with your application.

- Cash
- Money Order
- Bank Draft
- Cheque

Please make cheque or money order payable to the **Maritime School of Paramedicine**.

Supporting Documentation

All applicants are required to provide the following documentation for their application to be considered.

- Resume
A current copy of the applicant's resume highlighting work, community, recreation and extra curricular experiences and skills

Photocopies of the following valid certificates must accompany this application

- Official Transcript of Marks from High School (or equivalent)
Transcripts should be mailed directly from the institution to the Maritime School of Paramedicine, or be contained in a sealed envelope from the institution.
- Official Transcripts of Marks from any Post Secondary Degree or Diploma
Transcripts should be mailed directly from the institution to the Maritime School of Paramedicine, or be contained in a sealed envelope from the institution.
- Drivers License
A photocopy of a current provincial driver's license. Students must be eligible for a Nova Scotia Class 4 license by the start date of the program they are applying for. Eligibility requirements may be obtained from the Registry of Motor Vehicles.

Supporting Documentation

Driver's Abstract

A current copy of the applicant's driver's abstract (within the last 6 months) may be obtained from the Registry of Motor Vehicles.

Criminal Record Check

A current copy (within the last 6 months) may be obtained from your local police or RCMP detachment.

Two Reference Forms

Maybe obtained from the Maritime School of Paramedicine or downloaded from the website.

Medical Form

Completed by physician or public health official.

Immunization Record

Completed by physician or public health official. This is necessary to secure clinical placements throughout the program.

PCP applicants must also provide the following information:

Copy of Current First Aid and CPR certification

First Aid must be Emergency level or higher and CPR must be one-person adult rescuer or higher.

ACP, PRAP and PRRP applicants must also provide the following:

Confirmation of Registration as an Active Paramedic

*A copy of **both sides** of the provincial ID tag for Nova Scotia Paramedics or equivalent in other Provinces. Official documentation from the provincial registration body may also be accepted.*

Declaration

I hereby certify that all of the above information and all supporting documentation is complete and correct. I authorize the Maritime School of Paramedicine to verify any information provided as part of this application. I understand that withholding information or providing false information in this application and/or any supporting documentation may be considered grounds for non-acceptance, or after acceptance, grounds for dismissal. I agree to follow and be bound by the regulations of the Maritime School of Paramedicine, including any revisions, deletions or additions made to them in the future. If admitted I agree to pay all associated fees with my enrolment and the program.

DD	MM	YYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>

Signature

Date

Completed application forms, fees and all supporting documentation (ie. Transcripts) should be forwarded to the following address (via fax or regular mail) prior to the deadlines listed in the Academic Calendar:

The Maritime School of Paramedicine
Attention: Application Committee
88 Slayter Street
Dartmouth, Nova Scotia
Canada
B3A 2A6

All submitted documents become the property of the Maritime School of Paramedicine and cannot be returned or distributed to other institutions. Please allow at least 3 to 4 weeks for processing prior to calling the institution. To verify the status of your application, please call (902) 464-5288 or email admissions@msop.ca. Possession of the minimum requirements for each program does not guarantee admission into the program and students must attend one of the seat competitions prior to admission selections being made. Acceptance into many of the programs is limited due to the number of spaces available.

Medical Assessment Form

This individual has been under my care for _____ months / years.

Please identify any medical condition(s) that this person has that may affect his/her ability to complete a Primary/Advanced Care Paramedicine Program and then subsequently work in this occupation.

When considering what conditions to identify remember that this person must be eligible for a Class 4 Driver's License through the Department of Motor Vehicles of Nova Scotia and will have to complete a medical confirming this eligibility. The Maritime School of Paramedicine has the applicant perform a heavy lift test of 150 lbs during the interview process. They will have to complete a much more physically intensive test prior to being accepted for employment in the field involving cardiovascular exercises, endurance and heavy lifting.

Specific areas of concern are back, feet and general conditioning as they will be frequently asked to carry a stretcher with a patient up and down stairs. The candidate's psychological coping mechanisms will be repetitively tried as they will be exposed to stressful situations and be expected to communicate with families who are under extreme pressure.

They will be expected to shift work. Their work environment also predisposes them to a diet of fast food and a lack of exercise.

Date Identified	Illness/Injury
/	
/	
/	
/	
/	

Please use back of application if more space is required.

Do you consider this individual to be in: (Please identify the most appropriate answer)

Good or Above Average physical health

Poor or Below Average physical health

The Immunization Record (following page) must be completed by the physician or public health official and accompany this document. If your immunization record is incomplete many of the clinical sites used by the Maritime School of Paramedicine may refuse privileges to the student. Also consult with the physician regarding any other immunizations that may be available but are not required.

For each test indicate the name, phone number and address of the official verifying the test. This must be up to date and complete. Where blood work or other testing is indicated, please ensure documentation of successful immunization has occurred.

I verify that this individual appears to be in good physical and psychological health and fitness based upon my medical examinations and records.

Physician's Stamp (Including name and address):

Signature

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Date

Note: The information contained in the Medical Assessment Form and the Immunization Record will be kept confidential and will only be reviewed by the Admissions Committee. It may be necessary to provide this information to clinical sites as proof of immunization and health status in order to secure clinical placements. In this situation the student will be informed by the Maritime School of Paramedicine.

Immunization Record

Note: The information contained in the Medical Assessment Form and the Immunization Record will be kept confidential and will only be reviewed by the Admissions Committee. It may be necessary to provide this information to clinical sites as proof of immunization and health status in order to secure clinical placements. In this situation the student will be informed by the Maritime School of Paramedicine.

Tuberculosis Testing:

Note: Must have been completed within the last 12 months

Two step Tuberculin Skin Test: Negative Positive

If positive, were chest X-Rays completed? Yes No

Results _____

Has the individual received the BCG vaccine? Yes No

Has the individual received INH Therapy? Yes No

Name and Title of Health Care Professional: _____

Telephone: _____

Town, Province: _____

Relationship to Applicant (Eg. Family Physician): _____

Signature: _____

Chicken Pox:

Has the individual has a history of Chicken Pox? Yes No

If yes, please provide date (if known):

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If no, a vaccination against Varicella Zoster must be done. Please provide dates.

1.

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2.

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Name and Title of Health Care Professional: _____

Telephone: _____

Town, Province: _____

Relationship to Applicant (Eg. Family Physician): _____

Signature: _____

Rubella:

Has the individual been vaccinated against Rubella? Yes No

Blood work must be completed to ensure immunity. Please provide date:

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Was immunity successful? Yes No

Name and Title of Health Care Professional: _____

Telephone: _____

Town, Province: _____

Relationship to Applicant (Eg. Family Physician): _____

Signature: _____

Rubeola:

Has the individual been vaccinated against Rubeola? Yes No

Blood work must be completed to ensure immunity. Please provide date:

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Was immunity successful? Yes No

Name and Title of Health Care Professional: _____

Telephone: _____

Town, Province: _____

Relationship to Applicant (Eg. Family Physician): _____

Signature: _____

DPT:

Has the individual been immunized against DPT? Yes No

Please provide date:

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Name and Title of Health Care Professional: _____

Telephone: _____

Town, Province: _____

Relationship to Applicant (Eg. Family Physician): _____

Signature: _____

Tetanus:

Has the individual received a Tetanus Booster? Yes No

Please provide date:

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Name and Title of Health Care Professional: _____

Telephone: _____

Town, Province: _____

Relationship to Applicant (Eg. Family Physician): _____

Signature: _____

Hepatitis B:

Has the individual received vaccination against Hepatitis B? Yes No

Note: The applicant must have received a minimum of the first vaccination of this series

1st

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2nd

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3rd

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Name and Title of Health Care Professional: _____

Telephone: _____

Town, Province: _____

Relationship to Applicant (Eg. Family Physician): _____

Signature: _____

Influenza:

Note: Must have been completed within the last 12 months

Has this individual received vaccination against Influenza? Yes No

Please provide date:

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Name and Title of Health Care Professional: _____

Telephone: _____

Town, Province: _____

Relationship to Applicant (Eg. Family Physician): _____

Signature: _____