Introduction

Thank you for your interest in applying for the East Central Illinois EMS EMT Program. In this packet, you will find or be informed with everything required for you to apply and/or turn in to be considered for a position in our program. Please read carefully and be sure to have all paperwork handed in to the ECIEMS office no later than the date provided for the current course.

Program Goals
The goal for ECIEMS is to prepare competent, entry level EMT in the cognitive, psychomotor and affective learning domains.

Pre-Qualifications
To be qualified for review you must:

- Be 17 years of age or older. May not apply for licensure until age of 18.
- Have a high school diploma or equivalent of a 12-year certificate for licensure.
- Have no restrictions on operating as a healthcare provider within Illinois or within the East Central Illinois EMS system.
- Submit completed ECIEMS EMT Program Application.
- Satisfactorily have met any program Health and Immunization requirements, as outlined below.

Note: Submitting the application requirements will result in an admission decision. It will not guarantee acceptance to the program. All program admissions are dependent on seat availability in the classroom.

Discrimination
East Central Illinois EMS, a department of the OSF Healthcare System, considers students, employees, applicants for admission or employment and those seeking access to system programs solely on the basis of individual merit. OSF Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Health and Immunization
All students shall comply with the required immunizations and health screening to be considered for enrollment in the program. The student is responsible for all costs associated with obtaining and maintaining these requirements. All related documents, upon submission, will remain confidential and will be securely filed with the student's personal file throughout the duration of the program.

Complete or show proof of immunity:

- TB Testing
- MMR
- Varicella
- Hepatitis B
- Tdap
- Influenza (For Spring & Fall Classes)
- COVID-19 (Recommended, but not required)

Note: Failure to successfully complete any component of the immunization requirements shall result in dismissal from the program and forfeiture of any associated fees.

East Central Illinois EMS
•1400 W Park St | Urbana, IL | 61801•
Office: 217.359.6619 | **Fax:** 217.359.7408

East Central Illinois EMS

Course Fees

- The fee for the ECIEMS EMT Program is $1,400*.
- Fees for courses offered by ECIEMS will include the required textbooks with access codes.
- Course fees do not include any licensure/certification exam fee or State of Illinois Licensing fee.
- A deposit of $500 must be paid to be registered for the course, and the remaining course fees must be paid before the end of the second week of the course.

Withdrawing from a Course and Reimbursement of Course Fees

1. Any student withdrawing from an ECIEMS class **prior** to the **start** date will receive full reimbursement of the amount paid **minus** the cost of the textbook with the access code.
    a. Textbooks can be considered for buyback if a student should withdrawal from the program **prior** to the start of class **if** the following conditions have been met:
        i. The textbook shall be in **"NEW"** condition and free of defects not normally associated with a newly purchased look.
        ii. All access codes must be concealed behind the **original** scratch off cover.
        iii. All supplemental materials included with the book must also be returned and in **"NEW"** condition.
2. Any student withdrawing from the program within the first two weeks of a program will be eligible for up to a 50% reimbursement of the amount paid for that program, minus the cost of the textbook with the access code.

Attendance

Students are expected to attend all scheduled classes and clinicals on time.

- Tardiness greater than 15 minutes on more than two occasions does not meet the requirement for course completion.
- Absences exceeding 10% of classroom time disqualifies you from completing the program

Note: Classes cancelled due to weather will be announced. Any extraordinary circumstances causing attendance complications, please contact the Lead EMS Instructor as soon as possible.

In this packet you will find:

- East Central Illinois EMS EMT Program Application
- East Central Illinois Immunization Form (EMT Only)
- Ride Along Policy/Application
- Confidentiality Agreement

All forms must be completed and returned by date given to be considered for the program.
You must provide your own copy of your identification and proof of vaccinations. It is your responsibility to ensure all paperwork is filled out completely and returned by date given.

If you have any questions, please do not hesitate to call East Central Illinois EMS at 217-359-6619 Mon-Fri 0800-1630.

Thank you for your interest in applying for the East Central Illinois EMT Program.

*Prices are subject to change without notice

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East Central Illinois EMS

EMT Program Application Packet



Last Name: _____

Date Received: _____

__ HS or Equiv. __ State ID __HealthReq __App

East Central Illinois EMS

Application for Class

Personal Information (please print)

Full Name: _____

Street Address: _____

City, State, ZIP: _____

County: _____

Phone: _____ Alternate phone: _____

E-mail: _____ Date of Birth: _____/_____/_____

S.S.#: _____ - _____ - _____ Driver's License _____

IDPH License #: _____ (if applicable)

Affiliation/Department: _____ (if applicable)

Education: High School Attended: _____

Graduation Year: _____ or Year GED obtained: _____

Applicant Affidavit:

I hereby certify that all of the information provided is true, and that I:

- Am 17 years of age or older.
- Have not had any EMS license suspended or revoked.
- Have read and understand the East Central Illinois EMS System Education Policies for this course.

By signing this affidavit, I:

- authorize the East Central Illinois EMS System to request any and all records of my licensure, continuing education, or past EMS history from the Illinois Department of Public Health or the Illinois Department of Professional Regulation, and from my current EMS System Coordinator.
- give my consent for this form to be reviewed by the program director and released to clinical agencies for compliance audits.
- understand that failure to comply with policies including the grading scale and attendance requirements may result in corrective action, which could include dismissal from the course and denial of my ability to take a Licensure Examination.
- agree to abide by all of the policies of the course.

My signature indicates that I have read and understand this affidavit.

_____ _____/_____/_____

Signature of Applicant **Date**

_____

Printed Name of Applicant

East Central Illinois EMS

•1400 W Park St | Urbana, IL | 61801•

Office: 217.359.6619 | **Fax:** 217.359.7408

East Central Illinois EMS
Core Education Programs
Immunization Form

___EMS - EMT

Nondiscrimination Policy: OSF HealthCare complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. OSF HealthCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (Except where disability may be a factor in the occupational qualifications).

Submit completed forms to:

OSF HealthCare Sacred Heart Medical Center – Urbana
East Central Illinois EMS
1400 W Park St.
Urbana, IL 61801
Phone: 217-359-6619
www.osfhealthcare.org/ems/eciems/

LM 3/6/2025

ECIEMS Core Education

Program Descriptions

Program Technical Standards

Please refer to the following descriptions of technical standards for each core education program.

Emergency Medical Services - Emergency Medical Technician

Students in the Emergency Medical Technician (EMT) Program must attend a minimum of **36** hours of clinical training in which he/she will aid in the lifting and moving of patients to and from stretchers; pull, push, and control the movement of machinery, i.e., oxygen cylinders, cardiac monitors, and stretcher; perform CPR; view digital displays and monitor oscilloscope readouts; hear audible alarms; and auscultate blood pressures and heart and lung sounds; possess the ability to communicate sufficiently to serve the needs of patients, the public, and members of the health care team.

CORE EDUCATION Immunization Form

Part I **APPLICANT:** Complete this section. Please **PRINT.**

PROGRAM check one: ☐ EMS - EMT

Name_____
First MI Last

Address_____
Street City State Zip Code

Email _____ Birth date_____/_____/ _____
Month Day Year

Telephone_____ _____
(Primary) (Secondary)

NOTE: The student is required to maintain health insurance and/or be responsible for medical expenses incurred during a clinical rotation or field internship.

I request that this report be submitted to the appropriate Program Director at East Central Illinois EMS, OSF HealthCare Sacred Heart Medical Center - Urbana, 1400 W Park St. Urbana, IL 61801.

I hereby attest that medical information supplied includes all medical conditions that would affect my participation in a health professions program. I authorize release of current medical information on my medical history or current condition to clinical affiliates.

If false information is given, or if significant medical information is withheld, I understand I will be dismissed from the program.

Applicant Signature:_____Date: _____

Left Blank Intentionally

CORE EDUCATION Immunization Record

Part II

NOTE: The following immunizations or titers are required. A shot record must document all immunizations/titers unless immunization is given the day of the physical exam. **In addition to completing the physical form, if applicable, please provide a copy of all results & titer results.** Express results in numerical values. Titers and alternative testing, located on Appendix A.

TB skin test
PPD

Applicant must undergo a two-step PPD* prior to beginning the clinical experience.

Any two-step PPD dated within one year from the end of the course will be accepted.

*The second PPD should be completed 7-10 days after the first test is completed.

PPD	**Date**	**Results in mm**
1st PPD	___/___/___	_____
2nd PPD	___/___/___	_____

Mumps
Rubeola
Rubella
MMR

The applicant must have documented proof of two (2) MMR vaccinations.

MMR	**Date**
1st MMR injection	___/___/___
2nd MMR injection	___/___/___

Varicella

Chicken Pox

The applicant must have documented proof of two (2) Varicella vaccinations.

Varicella	**Date**
1st Varicella injection	___/___/___
2nd Varicella injection	___/___/___

Hepatitis B

The applicant must have documented proof of Hepatitis B vaccination series.

Hepatitis B	**Date**
1st Hepatitis injection	___/___/___
2nd Hepatitis injection	___/___/___
3rd Hepatitis injection	___/___/___

Tdap

The applicant must have documented proof of current tetanus toxoid vaccination within the past 10 years.

Tdap	**Date**
Tdap injection	___/___/___

Influenza

The applicant must have documented proof of current seasonal flu shot. (Courses starting within October 1 to April 30 only).

Flu Shot	**Date**
Flu Shot injection	___/___/___

COVID-19

The COVID-19 Vaccination is recommended.
Not required
Single dose vaccines mark N/A for 2nd injection.

Covid-19	**Date**	**Manufacture**
1st COVID injection	___/___/___	_____
2ND COVID injection	___/___/___	_____

Applicant Name: _____

CORE EDUCATION Immunization Record

Appendix A

NOTE: This form is to supplement the Immunization Record. **Please provide a copy of all immunological results & titer results.** Use of this page is only indicated for missing or incomplete data on the Immunization Record.

Express results in numerical values.

TB

If your current or any previous TB skin test resulted positive, a chest x-ray and reading will be required.

If you received a QuantiFERON®-TB Gold blood test, note those results here.

TB	**Date**	**Results**
Chest X-Ray	___/___/___	_____
QuantiFERON®-TB Gold	___/___/___	_____

Mumps
Rubeola
Rubella
MMR

MMR titers may be used to prove immunity.

If the applicant is not immune to MMR, they are required to obtain the MMR vaccination.

MMR	**Date**	**Titer Results**
Mumps titer	___/___/___	_____
Rubeola titer	___/___/___	_____
Rubella titer	___/___/___	_____
1st MMR	___/___/___	
2nd MMR	___/___/___	

Varicella

Chicken Pox

Varicella titers may be used to prove immunity.

Childhood infection is not proof of immunity.

If the applicant is not immune to Varicella, they are required to obtain two (2) Varicella vaccinations.

Varicella	**Date**	**Titer Results**
Varicella titer	___/___/___	_____
1st Varicella injection	___/___/___	
2nd Varicella injection	___/___/___	

Hepatitis B

Hepatitis B titers may be used to prove immunity.
If the applicant is not immune to Hep. B, they are required to obtain the Hep. B vaccination

Hepatitis B	**Date**	**Titer Results**
Hepatitis B titer	___/___/___	_____
1st Hep. B	___/___/___	
2nd Hep. B	___/___/___	
3rd Hep. B	___/___/___	

Applicant Name: _____

Category: East Central Illinois EMS **Page:** 1 of 2

Title: Clinical Ride Along

Executive Sponsor:

Original Policy Date:	2/2018
Current Effective Date:	1/2025
Last Review Date:	1/2025
Next Required Review Date:	1/2026

Policy applies to East Central Illinois EMS; OSF Sacred Heart Medical Center - Urbana.

I. PURPOSE

The purpose of this policy is to establish guidelines for individuals who are approved to ride with a contracted ambulance services provider.

II. DEFINITION –

A. Service – vetted and approved OSF contracted ambulance service provider.

III. PROCEDURE

A. Eligible persons must complete a series of forms to include:
   1. Confidentiality Agreement
   2. Ride-Along/Clinical Request Form
      a. Approved by the Service.

B. Attire:
   1. All clothing must be clean, neat, and in good repair
   2. Acceptable attire includes:
      a. Dress shirt or blouse
      b. Full length dress slacks or pants (no jeans of any color)
      c. Dress shoes, or black or white athletic shoes. Open-toed shoes are not permitted.
      d. Coat: EMS agency coat, or plain coat with no lettering or patches.
   3. Socks, stockings, or hosiery must be worn
   4. Hair should be secured as necessary to facilitate safety and infection control
   5. Post earrings are acceptable, however dangling earrings or other piercings should not be worn
   6. Riders should not wear perfume, cologne, or aftershave
   7. In the event the rider's attire is deemed inappropriate by the Service's Operation Supervisor (OS) on duty and/or the crew to which the rider is assigned, the rider's assignment will end for that session

C. Scheduling:
   1. A request form and enrollment packet form should be completed and returned to the course Lead Instructor prior to the course start date.

2. Once approved by the Service, riders will schedule their ride-along through the course Lead Instructor.
3. The Service may suspend the ride-along program or riders at any time. In this event, if needed, any riders already on the schedule will be notified that they need to reschedule.
4. Each rider must be fit for duty for the entirety of his/her shift. Decreased capacity for duty resulting from the effects of substances or inadequate rest qualifies as a lack of fitness for duty. Riders shall not ride for not more than 12 consecutive hours, ride/work for a combined total of not more than 18 consecutive hours, and take at least 6 hours off between work and/or ride-along shifts.

D. Ride-Along Roles and Responsibilities:
1. All riders will sign in upon arriving at the Service with the exception of those assigned to applicable duty stations.
    a. AMT East in Danville
    b. Tilton Emergency Services
2. Riders will conduct themselves in a professional manner. Any behavior deemed inappropriate by the crew to which the rider is assigned may result in the rider being dismissed.
3. Riders will ride with the crew assigned by the Service.
4. Riders will assist with patient care as directed by the Paramedic in charge of the call.
5. Members of ECIEMS may function at their training level at the discretion of the paramedic in charge of the call.
6. Out-of-system riders may function only at the level defined by the enrolled program.
7. Riders must sign out and return identification.
8. Riders will not discuss any patient-related matters outside of clinical experience. Breach of confidentiality will be formally addressed by the Service and ECIEMS system leadership.

E. Non-Compliance:
1. Any person not in compliance with any section of this policy may be asked to leave by the Service.
2. If a rider is dismissed due to non-compliance. the Service will provide details in writing of the circumstances surrounding the decision to ECIEMS.
3. Any rider sent home may be required to re-apply for ride-along consideration.

IV. IMPLEMENTATION FORMS AND OTHER DOCUMENTS

Ride-Along/Clinical Request Form
Confidentiality Agreement

V. RELATED SYSTEM OR MINISTRY POLICIES – None.

VI. REFERENCES – None.

OSF Sacred Heart Medical Center
East Central Illinois EMS

Ride-Along/Clinical Request Form

Name:_____ Phone: (H)_____

Address:_____ (W)_____

_____ E-mail:_____

City, State, Zip:_____ Emergency contact name/phone:_____

Organization:_____ _____

Are you an OSF HealthCare Employee? YES NO

If yes, state department and supervisor's name:_____

Current certification: MD RN EMT-P EMT-I EMT-B EMT Student Nursing Student

Other: _____

Specific date(s) & time(s) requested: _____

Reason for request: _____

I understand that riding in an emergency vehicle may be hazardous, and that such vehicles may be called upon to travel at high rates of speed through traffic and intersections, which may result in a substantial risk of injury to me as a consequence of accident or other event. I understand that I may come in contact with ill or injured persons who may present a risk of injury to me, and that I may be exposed to diseases or other hazardous or dangerous conditions which may present a risk of injury to me. I acknowledge that I am fully aware of the risks involved including those identified above and hereby assume full responsibility for any injury, loss, or damage which I or my property may receive in connection with my participation in this program.

I agree not to sue OSF Sacred Heart Medical Center - Urbana, OSF HealthCare System, their officers, directors, agents, employees, or servants, hereinafter referred to as "Releasee". I hereby release, exempt, and discharge OSF Sacred Heart Medical Center from any and all liability to me, my personal representatives, assigns, heirs and next of kin for all loses, whether caused by the negligence of the Releasee or otherwise, while participating in the Ride-Along Program. I further agree to indemnify, save, and hold harmless the Releasees from any or all losses, claims, actions, or proceedings of every kind and character which may be presented or initiated by any other person or organization and which arise directly or indirectly form my activities while participating in the Ride-Along Program.

I agree not to discuss any patient-related matters outside of the clinical experience, as outlined by HIPAA Regulations.

I have read and understand the Ride-Along/clinical policy, and I agree to comply with said policy. I have received a copy of the ambulance service's Trainee Confidentiality and Non-Disclosure Agreement.

Signature:_____ Date:_____

Printed Name:_____

This form is valid for one year from date signed.

(For Office Use Only)

_____Approved _____Denied _____Under Review

Guest/Trainee Confidentiality and Non-Disclosure Agreement

Advanced Medical Transport Guest/ Trainee Confidentiality and Non-Disclosure Agreement

I _____ acknowledge that patients provide and Advanced Medical Transport collects personal, confidential information verbally, in writing, and through digital means. I understand and agree that any information pertaining to patients is strictly confidential and protected by federal and state laws and that I will not use or disclose patient information in any way, unless Advanced Medical Transport authorizes me to do so.

I agree that I will comply with all HIPAA policies and procedures in place at Advanced Medical Transport during my experience as a guest/trainee with Advanced Medical Transport If at any time I knowingly or inadvertently breach patient confidentiality or violate the HIPAA policies and procedures of Advanced Medical Transport, I agree to notify Advanced Medical Transport immediately.

I also understand that I may be exposed to other confidential or proprietary information of Advanced Medical Transport and I agree not to reveal any of that information to anyone at any time, unless I am authorized by Advanced Medical Transport to do so. This means that I will not disclose information about Advanced Medical Transport's business practices or other information that Advanced Medical Transport might consider to be confidential or proprietary.

Failure to uphold these obligations may result in immediate suspension or termination of the privilege to gain clinical experience or observe the activities of Advanced Medical Transport. Upon termination of this privilege for any reason, or at any time upon request, I agree to return any and all patient information or confidential or proprietary information in my possession. I understand that any patient or confidential information that I see or hear while a guest/trainee will stay here at Advanced Medical Transport when I leave.

I have been given an overview of Advanced Medical Transport's HIPAA policies and procedures and have been given access to review those policies and I agree to abide by them.

Signature: _____ ***Date:*** _____

Name: _____

CONFIDENTIALITY AGREEMENT

Instructions

To be completed by employees, medical staff, students, volunteers, vendors, business associates, and any others who are permitted access to the OSF Healthcare Confidential Information.

I UNDERSTAND AND AGREE THAT IN THE COURSE OF MY WORK WITH OSF HEALTHCARE I WILL MAINTAIN THE PRIVACY, CONFIDENTIALITY AND SECURITY OF ALL OSF HEALTHCARE INFORMATION IN ACCORDANCE WITH THIS CONFIDENTIALITY AGREEMENT AND ALL APPLICABLE OSF HEALTHCARE POLICIES AND PROCEDURES ("OSF HEALTHCARE POLICIES").

Definition of Confidential Information ("CI")

I understand that CI includes:

- Confidential and/or proprietary information about OSF Healthcare Network and its affiliates.
- Information from any source and in any form, including, paper record, oral communication, audio recording, and electronic display.
- Patient Protected Health Information ("**PHI**"), including information in medical records, billing records, and conversations about patients.
- Personnel information, including payroll, discipline or other information about employees, volunteers, students, contractors, or medical staff.
- Confidential business information of third parties having a relationship with OSF Healthcare, including information about third-party software and other licensed products or processes, operations, quality improvement, peer review, education, billing, reimbursement, administration, or research (such as utilization reports, survey results, and related presentations).

Access/Use/Disclosure Agreement

I understand and agree that with respect to any CI to which I am granted access:

1. For Job-Related Purposes Only. I will only access, use and disclose CI for a legitimate job-related reason and strictly on a need-to-know basis, and that I will limit my access, use and disclosure to the minimum amount necessary to accomplish the legitimate intended purpose of the access, use and disclosure.
2. PHI Privacy/Security. I will protect the privacy, confidentiality and security of PHI, including all PHI in electronic medical records ("**EMR**"), in accordance with legal requirements and OSF Healthcare Policies.
3. Business Associate Agreement. I understand that if I am a vendor that will have access to PHI in the course of performing services for OSF Healthcare, a Business Associate Agreement must be signed by me or my company prior to me and/or my company receiving access to PHI.
4. Training. I will complete all required privacy and security training for accessing EMR or other CI.
5. Inappropriate Access. I will not access or obtain my own, a friend's, or a family member's information maintained by OSF Healthcare without appropriate written authorization and consistent with OSF Healthcare Policies.
6. No Use of Mobile Device/Removable Media. I will not maintain CI on any mobile device (laptop, smartphone, tablet, etc.) that is not encrypted, will not electronically transmit CI in an unsecured manner or to an unencrypted mobile device and will not copy and store any CI on any removable media (e.g. flash drives).

7. Protection of Credentials. I will not disclose to another person my sign-on code and/or password, and will not use another person's sign-on code/password for accessing EMR or other CI. I will not leave a secured application unattended while I am signed on.
8. Secured Application. I will not attempt to access a secured application or restricted area without proper authorization or for purposes other than official OSF Healthcare business.
9. No Unauthorized Copying/Alteration/Destruction. I will not copy, alter or destroy CI unless such action is part of my job or the services that I am responsible for providing to OSF Healthcare, in which case I will only copy, alter or destroy CI in accordance with applicable OSF Healthcare policies and procedures.
10. Reporting of Issues. I will immediately report to my supervisor or the appropriate OSF Healthcare representative responsible for overseeing the provision of services by me and my company any known or suspected (a) use of my password by someone other than me, or (b) inappropriate access, use or disclosure of CI. If my supervisor or responsible representative is not available, I will notify the System Compliance Officer and/or Privacy Officer.
11. Safeguarding OSF Healthcare Property. I will safeguard from loss, theft, or unauthorized use, disclosure and access all OSF Healthcare owned equipment/property that is placed in my control and on which CI is stored or through which CI may be accessed.
12. Use of Personal Equipment/Property. I will not store or transmit CI via my or my company's personal equipment/property unless permitted by and in accordance with applicable OSF Healthcare Policies. If any OSF Healthcare PHI is stored or transmitted with my or my company's equipment/property, I will ensure that all such CI is properly encrypted in accordance with HIPAA encryption standards.
13. No Social Media/Blogging. I will not post or discuss CI of any type on any social media sites, blogs, discussion groups and the like unless pre-approved by OSF Healthcare.
14. No recordings. I will not take photographs, make videos, or make other recordings of patients, staff, or visitors except in accordance with OSF Healthcare Policies.
15. Auditing. I understand that my access to CI and my OSF Healthcare email and other information system accounts may be audited.
16. Ownership of Information. OSF Healthcare will retain ownership of all rights, title and interest in and to the CI and no rights are transferred to me by virtue of my access to CI.
17. Return of Information/Continuing Obligations. I WILL RETURN ALL CI TO OSF HEALTHCARE AND WILL NOT TAKE ANY CONFIDENTIAL INFORMATION WITH ME WHEN MY WORK AT OSF HEALTHCARE ENDS. I UNDERSTAND THAT EVEN AFTER MY WORK ENDS I WILL CONTINUE TO BE REQUIRED TO KEEP ALL CI WHICH I HAD ACCESS CONFIDENTIAL.

I have read, understand and agree to comply with the terms of this Confidentiality Agreement and all applicable OSF Healthcare policies and procedures. I understand that my failure to comply with this Confidentiality Agreement may result in termination of access to OSF Healthcare systems, disciplinary action, up to and including termination of employment or student access, loss of OSF Healthcare privileges or contractual or affiliation rights and/or legal action.

Name: _____
(Please Print)

Signature: _____ Date: _____