Wilson Community College Regional Fire/Rescue Academy Cadet Application Packet

Wilson Community College • Attention: Ben Smith
902 Herring Ave • PO Box 4305 • Wilson, NC 27893

252-246-1372 • 252-291-1195

Academy Check Sheet

All of the following must be completed and returned to be accepted into the Wilson Community College Fire/Rescue Academy.

- ❑ Completed Cadet Application Packet (*this document*), including
  - ❑ Department Affiliation Validation
  - ❑ Signed Cadet/Testing Contract
  - ❑ Notarized Academy Records Statement
- ❑ Copy of Driver's License
- ❑ Copy of High School Diploma (*or equivalent*)
- ❑ Drug Screen Results (*10-panel test*)
- ❑ Cholesterol Screening Test
- ❑ Hepatitis B Series *(first shot required by registration)*
- ❑ TB Skin Test
- ❑ Completed Medical Form (*see medical form included in application packet*)
- ❑ The required textbooks include:
  - ❑ Jones & Bartlett: *"Fundamentals of Firefighter Skills and Hazardous Materials Response"* Fourth Edition
  - ❑ Jones & Bartlett: *"First Aid, CPR, and AED Standard"* Eighth Edition
  - ❑ Jones & Bartlett: *"Fire Service Rapid Intervention Crews"* First Edition

For information on housing assistance, contact Ben Smith, Director of Health and Emergency Services for Wilson Community College, at bsmith@wilsoncc.edu or 252-246-1372.

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Applicant Information

INSTRUCTIONS: Please type or print legibly in ink. Fill out this form completely and accurately. If an item does not apply to you, indicate by entering N/A in the blank.

Full Legal Name: _____
(First) *(Middle)* *(Last)* *(Suffix)*

Preferred Name: _____ Social Security Number: _____

Mailing Address: _____

_____

Cell Phone: _____ Other Phone: _____

Email Address: _____

Date of Birth: _____ Place of Birth: _____ *(City/State)*

Citizenship: ❑ U.S. Born ❑ U.S. Naturalized ❑ Other - Please specify: _____

Education: Completed High School Diploma or equivalent? Yes No *(circle yes or no)*

Have you served in the U.S. Military? Yes No *(circle yes or no)*

If yes, which branch of service? _____ Type of discharge? _____

Emergency Contact Information *(please provide minimum 1 emergency contact)*:

Name/Relationship: _____ Contact Number: _____

Name/Relationship: _____ Contact Number: _____

Name/Relationship: _____ Contact Number: _____

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Fire Department Affiliation Validation

(completed by affiliated Fire/Rescue Agency)

I acknowledge that _____ *(please print cadet applicant name)* is affiliated and in good standing with _____ *(please print fire/rescue agency name).*

By requesting the admission of the individual, I am attesting that I am aware of nothing in this person's character or reputation that would bring discredit upon this department/agency, emergency services, or Wilson Community College.

In the event this cadet applicant is not currently a paid employee of this agency, he/she understands that this letter does not guarantee or promise employment with this or any other agency, nor does this letter express or imply a guarantee of future employment in this department or any other agency.

I reserve the right to revoke our affiliation with this cadet applicant for any reason and at any time deemed appropriate by this agency. I agree to notify Wilson Community College immediately of any affiliation change with this cadet applicant.

This affiliated agency agrees to supply the cadet applicant with the necessary personal protective ensemble to safely participate in fire/rescue training to include full complement of structural firefighting ensemble with Self Contained Breathing Apparatus and extra cylinder. The personal protective ensemble shall be of good working condition and compliant with applicable industry standards.

Fire Chief/Department Head Signature: _____

Fire Chief/Department Head Printed Name: _____

Date: _____

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Cadet Contract

As a cadet in the Wilson Community College Fire/Rescue Academy, I understand, and agree to:

1. Pass all exams with a score of 70 or above.
2. Follow all testing procedures as outlined in the Policy of Testing and the Testing Contract.
3. Follow all Policies and Procedures *(see supplemental document)*
4. Participate in physical training each day, unless excused by a physician.
5. Complete all required hours of physical training and the physical fitness test.
6. Clean the Training Center each day, and conduct any details as directed.
7. Be on time for all classes.
8. No use of tobacco products or substitute thereof during Academy hours.
9. No use of electronic communication devices during Academy hours. No cell phones allowed in the classroom.

Cadet Testing Policy Contract

As a cadet in the Wilson Community College Fire/Rescue Academy, I understand:

1. I must pass the practical test by a minimum score of 70% to qualify to take written test.
2. If I fail the practical test on the first attempt, I can retest once with no coaching from the instructor. If I fail a second time, I will be dismissed from the academy.
3. Tested cadets must be separated from the untested cadets until the testing session is completed.
4. Cadets must be seated at least one foot apart from each other.
5. I must remove all items from the table with exception of the test booklet, answer sheet, and two No. 2 pencils or pens.
6. I must fill out my information on the answer sheet.
7. I will have 60 seconds to answer each question on each exam.
8. I must make 70% for a passing score. Any cadet receiving less than 70% will be notified and allowed to retest once.
9. I cannot make any marks on the test booklet.

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10. I cannot talk during the test, and no cheating is allowed. This will cause a failing score.
11. I cannot use electronic communication devices during test time.
12. If I fail a weekly exam, one re-take will be allowed. If a Cadet does not pass the re-take exam, the Cadet will be automatically dismissed. If any Cadet fails four written exams, the Cadet will be automatically dismissed.
13. If I have a question about a test question, I should raise my hand, and the proctor will read the question to me.
14. There is only one correct answer for each question. An unmarked question and/or two-marked answers will be counted incorrect.
15. If I should want to change a marked answer, completely erase or put an "X" through the one I want to change and mark another choice.
16. Once I complete the test, turn in both the test and the answer sheet and leave the room.

I hereby certify that I will comply with each and every statement made on this form, and understand that any misstatement or omission of information will subject me to disqualifications or dismissal.

_____ _____

Cadet Applicant Name *(please print)* Cadet Applicant Name *(signature)*

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Academy Records

(must be notarized)

I hereby certify that each and every statement made on this form is true and complete, and I understand that misstatement or omission of information will subject me to disqualifications and/or dismissal.

I here by give my permission to Wilson Community College and N.C. Department of Community Colleges to release my certification training records to the N.C. Fire Rescue Commission and my sponsoring agency.

_____ _____

Cadet Applicant Name *(please print)* Cadet Applicant Name *(signature)*

STATE OF NORTH CAROLINA

COUNTY OF _____

This the _____ day of _____ 20 _____

Subscribed and sworn to before me,

this the _____ day of _____ 20 _____

_____

Notary Public (Official Seal)

My Commission Expires

_____20, _____

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REPORT OF MEDICAL HISTORY *(Please print in black ink)* *To be completed by student*

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN NAME PERSONAL ID#(PID) *SOCIAL SECURITY NUMBER

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

DATE OF BIRTH (mo/day/yr)_____ GENDER ☐ M ☐ F MARITAL STATUS ☐ S ☐ M ☐ OTHER EMAIL_____

CLASS YOU ARE ENTERING (circle):
FR. SO. JR. SR. GRAD. PROF.

PREVIOUSLY ENROLLED HERE ☐ YES ☐ NO
IF YES, DATES _____
PREVIOUSLY A PATIENT HERE ☐ YES ☐ NO
IF YES, DATES _____

SEMESTER ENTERING (circle): FALL SPRING
SUMMER 1 SUMMER 2 OTHER YEAR 20____

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) AREA CODE/TELEPHONE NUMBER

NAME OF POLICY HOLDER *SOCIAL SECURITY NUMBER EMPLOYER

POLICY OR CERTIFICATE NUMBER GROUP NUMBER IS THIS AN HMO/PPO/MANAGED CARE PLAN? ☐ YES ☐ NO

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. *Please attach additional sheets for any items that require fuller explanation.*

FAMILY & PERSONAL HEALTH HISTORY *(Please print in black ink)* *To be completed by student*

Has any person, related by blood, had any of the following:

	Yes	No	Relationship
High blood pressure			
Stroke			
Heart attack before age 55			
Blood or clotting disorder			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Cancer (type):			
Alcohol/drug problems			
Psychiatric illness			
Suicide			

HEIGHT _____ WEIGHT _____

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year
High blood pressure			
Rheumatic fever			
Heart trouble			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Head or neck radiation treatments			
Tumor or cancer (specify)			
Malaria			
Thyroid trouble			
Diabetes			
Serious skin disease			
Mononucleosis			

	Yes	No	Year
Hay fever			
Allergy injection therapy			
Arthritis			
Concussion			
Frequent or severe headache			
Dizziness or fainting spells			
Severe head injury			
Paralysis			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Pilonidal cyst			
Frequent vomiting			
Gall bladder trouble or gallstones			

	Yes	No	Year
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent abdominal pain			
Hernia			
Easy fatigability			
Anemia or Sickle Cell Anemia			
Eye trouble besides need glasses			
Bone, joint, or other deformity			
Knee problems			
Recurrent back pain			
Neck injury			
Back injury			
Broken bone (specify)			
Kidney infection			
Bladder infection			

	Yes	No	Year
Kidney stones			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Sexually transmitted			
Blood transfusion			
Alcohol use			
Drug use			
Anorexia/Bulimia			
Smoke 1+ pack cigarettes/week			
Regularly exercise			
Wear seat belt			
Other (specify)			

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

* Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.

FAMILY & PERSONAL HEALTH HISTORY-CONTINUED *(Please print in black ink) To be completed by student*

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet). Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)			

IMPORTANT INFORMATION….PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT /GUARDIAN, IF STUDENT UNDER AGE 18):

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service. **(Not applicable to community colleges.)**

(C) I am aware that the Student Health Service charges for some services and I may be billed through the University Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage. **(Not applicable to community colleges.)**

Signature of Student **Date**

Signature of Parent/Guardian, if student under age 18 **Date**

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT – The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit.

Acceptable Records of Your Immunizations May be Obtained from Any of the Following: (Be certain that your name date of birth, and ID Number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and year. **Keep a copy for your records.**)

- High School Records – These may contain some, but not all of your immunization information. Contact Student Services for help if needed. **Your immunization records do not transfer automatically. You must request a copy.**
- Personal Shot Records – Must be verified by a doctor's stamp or signature or by a clinic or health department stamp.
- Local Health Department
- Military Records or WHO (World Health Organization Documents)
- Previous College or University – **Your immunization records do not transfer automatically. You must request a copy.**

SECTION A:	**IMMUNIZATION REQUIREMENTS ACCORDING TO AGE**			
STUDENTS 17 YEARS OF AGE AND YOUNGER				
DTP or Td[1]	Polio	Measles[2]	Mumps[4]	Rubella[4]
3	3	2	1	1
STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER				
DTP or Td[1]	Polio	Measles[2,3]	Mumps[4]	Rubella[4]
3	0	2	1	1
STUDENTS BORN BEFORE 1957				
DTP or Td[1]	Polio	Measles	Mumps	Rubella[4]
3	0	0	0	1
STUDENTS 50 YEARS OF AGE AND OLDER				
DTP or Td[1]	Polio	Measles	Mumps	Rubella
3	0	0	0	0
INTERNATIONAL STUDENTS				
Vaccine Required				
Vaccines are required according to age (refer to appropriate box). Additionally, International students are required to have a TB skin test and negative result within the 12 months preceding the first day of classes (chest x-ray required if test is positive).				

1. DTP (Diphtheria, Tetanus, Pertussis), Td (Tetanus, Diphtheria): One Td booster within the last ten years
2. Measles: One dose on or after 12 months of age; second at least 30 days later. Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.
3. Two measles doses if entering college for the first time after July 1, 1994.
4. One dose on or after 12 months of age. Only laboratory proof of immunity to rubella or mumps disease is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

SECTION B:	These vaccines are **RECOMMENDED**. Some may be required by certain departments. Consult your college or department for specific requirements.

North Carolina House Bill 825 requires public and private institutions with on-campus residents to provide information about meningococcal disease. Attached to this form is information regarding meningococcal disease, including recommendations from the Centers for Disease Control of the U.S. Public Health Service. Please record on page 6 of this form, whether or not you have received the meningococcal vaccine. If **yes**, please note the month, day, and year of the vaccination.

SECTION C:	These vaccines are **OPTIONAL**.

IMMUNIZATION RECORD	**(Please print in black ink) To be completed and signed by physician or clinic. A complete immunization record from a physician or clinic may be attached to this form.**

				Personal ID# (PID)
Last Name	First Name	Middle Name	Date of Birth (mo./day/year)	*Social Security #

SECTION A REQUIRED IMMUNIZATIONS

	mo./day/year	mo./day/year	mo./day/year	mo./day/year
• DTP or Td	(#1)	(#2)	(#3)	(#4)
• Td booster				
• Polio				
• MMR (after first birthday)				
• MR (after first birthday)				
• Measles (after first birthday)			**Disease Date	****Titer Date & Result
• Mumps			***(Disease Date NOT Accepted)	****Titer Date & Result
• Rubella			***(Disease Date NOT Accepted)	****Titer Date & Result

SECTION B RECOMMENDED IMMUNIZATIONS

The following immunizations are recommended for all students and may be required by certain colleges or departments (for example, health sciences). Please consult your college or department materials for specific requirements.

Meningococcal	Received the meningococcal vaccine? **No** ☐ **Yes** ☐
If **Yes**, please indicate date(s) vaccine was received (mo./day/year)	

	mo./day/year	mo./day/year	mo./day/year	
• Hepatitis B series only (**REQUIRED**)				****Titer Date & Result
OR				
• Hepatitis A/B combination series				
• Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	****Titer Date & Result
• Tuberculin (PPD) Test (**REQUIRED**)				
(within 12 months) mm induration				
Chest x-ray, if positive PPD Date				
Results				
Treatment if applicable Date				

SECTION C OPTIONAL IMMUNIZATIONS

	mo./day/year	mo./day/year	mo./day/year
• Haemophilus influenzae type b			
• Pneumococcal			
• Hepatitis A series only			
• Other			

Signature or Clinic Stamp REQUIRED:

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

Office Address **City** **State** **Zip Code**

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** Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.

*** Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

**** Attach Lab report

Do Not Write in This Space

PHYSICAL EXAMINATION *(Please print in black ink) To be completed and **signed** by physician or clinic*

A physical examination is required by **some schools and/or programs** (consult your college or department for specific requirements). **If required**, it must be completed in black ink and signed by a physician or clinic.

Last Name First Name Middle Name	Date of Birth (mo/day/year)	*Social Security Number

Permanent Address City State Zip Code	Area Code/Phone Number

Height _____ Weight_____ TPR _____/_____/_____ BP _____/_____

IF REQUIRED:

Vision: Corrected Right 20/ _____ Left 20/ _____

Uncorrected Right 20/ _____ Left 20/ _____

Color Vision _____

Hearing: (gross) Right _____ Left _____

15 ft. Right _____ Left _____

IF REQUIRED:

Urinalysis: Sugar:_____ Albumin _____

Micro _____

Hgb or Hct (if indicated) _____

STS (may be required by some departments)

Date _____ Results _____

Recommendations _____

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

A. Is there loss or seriously impaired function of any paired organs? Yes _____ No _____
Explain _____

B. Is student under treatment for any medical or emotional condition? Yes _____ No _____
Explain _____

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited _____ Limited _____
Explain _____

D. Is student physically and emotionally healthy? Yes _____ No _____
Explain _____

• Only for Students Admitted to a **HEALTH SCIENCES PROGRAM** •

Based on my assessment of this student's physical and emotional health on _____ (Date), he/she appears able to participate in the activities of a health profession in a clinical setting. Yes_____ No_____ if no, please explain _____

_____ _____

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

_____ _____

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

_____

Office Address **City** **State** **Zip Code**

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