THE VIRGIN ISLANDS DEPARTMENT OF EDUCATION
RAPHAEL O. WHEATLEY SKILL CENTER
A Post-Secondary Career & Technical Education Institute
P. O. Box 9337-- St. Thomas, U.S. Virgin Islands 00801
Tel: (340) 774-6277; Fax: (340) 777-5444
Mario Francis, Principal
mario.francis@vide.vi

EMT ADMISSIONS APPLICATION PACKAGE

Please accurately fill out the required information to process your application effectively.

Applicant's Name: _____

Date: _____

Raphael O. Wheatley Skill Center
EMT Program
Required Documentation

This list of items are required for your application to be complete. Your application must be complete before the date of your interview.

The following documents must be included with your application:

- ☐ High School Diploma (must see original)
  - Diploma
  - GED
  - Transcript
- ☐ Physical Examination Form
- ☐ Immunization Record (Updated)
- ☐ Police Record (Current)
- ☐ Traffic Record (Current)
- ☐ Identification Card
  - Driver's License (Mandatory)
  - Voter's ID
  - Passport
- ☐ Social Security Card/Birth Certificate
- ☐ Reference Form (Completed)
- ☐ Essay
- ☐ License/Certification (Optional) (Medical training certifications)

The application and all required documents must be turned in, for enrollment in the EMT Program.

Raphael O. Wheatley Skill Center
EMT Program
Course Information

Training Program:	Emergency Medical Technician - Basic
Course Medical Director	Gilbert Comissiong, MD
EMS Program Coordinator **Course Coordinator**	Mario Francis Office Number: (340) 227-2730 e-mail: mario.francis@vide.vi
Clinical Coordinator	
Lead Instructor	Emmet A. Petersen Sr. Contact Number: (340) 513-2531 E-mail: captpete11@hotmail.com
Course Approval #:	
Class Dates:	
Class Meeting Days / Times:	Mon-Fri 6:00 pm – 8:30 pm

Clinical Requirements:

Department	Hours	Skills Requirements	Qty.
Emergency Department	20	Births Witnessed	1
Respiratory Therapy	8		
Labor & Delivery	12		

Contact Requirements:

Age Group	Qty.	Type	Qty.
Adult	10	Psychiatric	5
Geriatric	5	Respiratory	5
Pediatric	10	Cardiac	5
		Obstetrical	5
		Medical	10
		Trauma	10

Internship Requirements

Hours	40 Hrs.
Patient Transport	5

I have had the above clinical requirements explained to me and I understand and will comply with these requirements.

_____ _____ _____

Printed Name Signature Date

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Application for Admission

Check a Box:
Male ☐ Female ☐

Personal Information: (List current information)

Name: _____
Last First Middle Maiden Name

Physical Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Social Security No.: _____

Citizenship Status: _____

Home Phone: _____ Mobile Phone: _____

Date of Birth: _____

Education: (List those that apply to you)

High School: _____

Address (City, State & Zip): _____

Year of Graduation: _____

GED: _____

Address (City, State & Zip): _____

Year of Graduation: _____ Certificate No.: _____

College/University: _____

Address (City, State & Zip): _____

Year of Graduation: _____ Degree: _____

School of Nursing: _____

Address (City, State & Zip): _____

Year of Graduation: _____ Degree: _____

Vocational/Trade School: _____

Address (City, State & Zip): _____

Year of Graduation: _____

Employment: (List most recent first)

Employer: _____

Position Title: _____

Address: (City, State, & Zip): _____

Dates: From _____ To: _____

Employer: _____

Position Title: _____

Address: (City, State, & Zip): _____

Dates: From _____ To: _____

Employer: _____

Position Title: _____

Address: (City, State, & Zip): _____

Dates: From _____ To: _____

Employer: _____

Position Title: _____

Address: (City, State, & Zip): _____

Dates: From _____ To: _____

Contact in case of emergency:

Name: _____

Relationship: _____

Address (City, State, & Zip): _____

Phone No.: _____

Mandatory Questions: (Please answer the following)

1. How do you plan to pay for your education?

2. How do you plan to care for your minor while you are in school?

3. Have you ever been convicted of a felony? Yes ☐ No ☐
   If yes, please explain.

Mandatory Essay

Using the space below, briefly tell us something about yourself and about your decision to apply at the Raphael O. Wheatley Skill Center Emergency Medical Technical Technician program. Please indicate reasons for choosing the EMT Program.

I hereby certify the information on this application accurate and complete.

Signature: _____ Date: _____

Reference Form

Section A: (to be completed by applicant)

Name: _____
Last First Middle Maiden Name

Physical Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Section B: (message to the person serving as a reference)

The person mentioned above is applying to the Raphael O. Wheatley Skill Center Emergency Medical Technician Program and is requesting you to serve as a reference. Thoughtful evaluations shared through reference letters are helpful to the committee on admission. References for admission purposes shall be kept confidential.

We wish to select capable men and women who have given serious consideration to their interest in EMT and who will profit most from the type of vocational educational offered by this school. Intellectual and personal qualifications play equally important roles in EMT.

Please use the reverse side for your reference. Additional comments may be added.

Return to: Raphael O. Wheatley Skill Center
P. O. Box 9337
St. Thomas VI 00801

Section C. (To be completed by the person serving as a reference.)

Please **TYPE** or **PRINT** clearly.

Name: _____

Relationship: _____

How long have you known applicant? (Years, Months) _____

Capacity in which you have known applicant:

- ☐ Job Supervisor/Employer
- ☐ Clergy
- ☐ High School Teacher
- ☐ College Instructor
- ☐ Volunteer Supervisor
- ☐ Coach
- ☐ Other (Specify): _____

1. What are the first words that come to mind to describe the applicant?

2. How do they interact with others? Please describe.

3. Is this individual a motivated self-starter? Please give examples.

4. Please describe the applicant's degree of maturity and independence.

5. How would you evaluate the applicant's communication skills, both in getting ideas across and resolving conflict?

6. Is this applicant willing to try new things, open to new people and to experiences not encountered before? Please give examples.

7. Would you have any reservation in recommending the applicant to the Emergency Medical Technician Program? Why or why not?

8. Please use this space to include anything else about the applicant that may help in determining his/her qualifications.

Reference Signature: _____ Date: _____

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CANDIDATE HEALTH SCREEN FORM

DEMOGRAPHICS

Candidate Name _____

Date of Birth _____ Sex_____

Address: _____
Street City State Zip

Home Phone: _____

Emergency Contact _____ Relationship_____

Contact Number _____ Allergies_____

Medical Problems:

1. _____
2. _____
3. _____
4. _____

Medications: (including dosage)

1. _____
2. _____
3. _____
4. _____

Have you ever been treated for Hepatitis or any other contagious? _____

Do you have a history of any of the following conditions/disease: (indicate only yes answers)

- ☐ Frequent Headaches
- ☐ Fainting
- ☐ Excessive Fatigue
- ☐ Asthma or Hay Fever
- ☐ Unusual Gain/Loss of Wt.
- ☐ Persistent Cough
- ☐ Allergies
- ☐ Venereal Disease
- ☐ Injury/Back Trouble
- ☐ Any other illness, abnormality/co[illegible]itions (describe below)
- ☐

- ☑ Diabetes
- ☐ Pain in Chest
- ☐ Fever/Night Sweats
- ☐ Shortness of Breath
- ☐ Frequent Indigestion
- ☐ Rheumatism/Arthritis
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ Operations (describe below)
- ☐

- ☐ Hernia/Rupture
- ☐ Varicose Veins
- ☐ Fractures
- ☐ Hemorrhoids
- ☐ Painful/Swollen Ankles
- ☐ Convulsions
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Nervous/Mental Problems
- ☐

Height_____ Weight_____ B/P_____ Pulse _____

*Physicians Signature*_____

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Application of Admission Checklist

Applicant: _____
Interview Date: _____
Interview Time: _____

Police Record	
Traffic Record	
Immunization Card	
Identification Card	
Driver's License (Mandatory)	
Voter's ID (optional)	
Passport (optional)	
High School	
Diploma	
Transcript	
GED	
Social Security Card	
Birth Certificate	
Health Screen Form	
MD Signature	
Reference Form	
Essay	
License (optional) (Medical Training Certification)	