

The Emergency Medical Technician (EMT) Program at INHS Health Training is designed for career opportunities with Ambulance Services, Fire Departments, Hospitals and other rescue departments. This program meets the requirements for education of EMTs as recommended by the U.S. Department of Transportation and required by the State of Washington.

Students are eligible for the National Registry of EMTs Computer Based Test (CBT) certifying exam for EMTs upon successful completion of the program.

### Application Requirements:

- Be 17 years of age on the first day of class and 18 years of age to complete field internship
- Have a high school diploma or its equivalent
- Be physically capable of performing the essential duties of an EMT
- Hold a current CPR course completion card at the American Heart Association "Healthcare Provider" level or the American Red Cross "CPR for the Professional Rescuer" level (we will give you this certificate during our in person program and it is included in the price of the course, online students are required to obtain this outside of their respective course.)

### Application Procedure:

You may apply for admission into the EMT Course by completing the application in this packet. The application deadline is two (2) weeks prior to the start of the course and a maximum of 32 students will be accepted on a first come-first serve basis.

### Selection Process:

- Applications will be reviewed only after all required information has been received by INHS Health Training to include application and registration
- Candidates who meet the required prerequisites will be accepted into the next available class
- INHS Health Training accepts a maximum of 32 students into each class
- Online students will not be granted access to course curriculum until all required paperwork has been received

### Course Fees:

Tuition:		\$1202.00
Textbook with Online Lab Access	In Person \$ 270.00 / Online \$ 325.00	
Lab Fees:	In Person \$ 133.00 / Online \$ 78.00	

### Post Selection Process:

Complete the payment process

- Pay tuition, book(s) and lab fees in full
- Collect all required immunizations records for submission at the start of course

Other options include:

- Make payment plan arrangements (only tuition can be included in the payment plan option)
- Complete Payment Plan Agreement and submit payment for book(s) and lab fees



**Please ensure you have attached all required information. It is strongly recommended applicants keep this information for future reference.**

Your completed application packet should include the following which needs to be submitted in its entirety:

- ✓ Completed and signed application
- ✓ Copy of your high school diploma or equivalent
- ✓ Copy of your current driver's license or state issued identification card
- ✓ Signed release form for the criminal background check
- ✓ Copy of your current American Heart Association Healthcare Provider (or equivalent) CPR card (only if you have already taken the course; it is offered as part of the in-person EMT course. Online students will need to have their card prior to registration)

**Upon acceptance into program, applicant must complete/supply the following:**

- ✓ Create an account or log into your account at [courseregistration.inhs.org](http://courseregistration.inhs.org) to register and pay for the course (if not paying in full at time of registration, a minimum payment of the book and lab fees must be paid 2 weeks prior to class; INHS will contact you for payment arrangements)
- ✓ Students will need to submit complete immunization records including but not limited to:
  - Measles, Mumps, Rubella, Rubeola
  - Varicella
  - TB test results (results must be within the immediate past year)
  - Hepatitis B series, if not completed, documentation of starting the series
  - Tetanus (administered after the age of 12)If copies of records are not available, titers may be used to show immunization status. Immunizations are required to take an INHS Vocational Education course.

Thank you for choosing the INHS EMT Program. For questions about the program or application process, please call (509)242-4264 or email [INHSEducation@inhs.org](mailto:INHSEducation@inhs.org).

**Please complete application and return to:**

INHS Community Wellness Center  
501 N. Riverpoint Blvd., Suite 245  
Spokane, WA 99202

Or email to: [INHSEducation@inhs.org](mailto:INHSEducation@inhs.org)

Or fax to: (509)232-8344



**Please complete application and return to:**

INHS Health Training  
501 N. Riverpoint, Suite 245  
Spokane, WA 99202  
(509)242-4264

In Person  Online   
Course Start Date: \_\_\_\_\_

**Demographic Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_ Birthdate \_\_\_\_\_

Driver's License Number/ State \_\_\_\_\_ Expiration \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other \_\_\_\_\_

**EMS Agency Data (if applicable)**

EMS Agency Affiliation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Fire Chief or Supervisor \_\_\_\_\_ Phone \_\_\_\_\_

**Academic Performance**

Please submit one of the following documents with your application.

Academic Documentation Type	Year Completed	School
GED Certificate		
High School Diploma		
College Degree		

I certify the above information is accurate and complete.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Pursuant to the requirements set forth by governing entities, INHS must ask you to complete the following disclosure statement. This information will be kept confidential. Please answer fully and accurately.

Note: INHS will confirm your answers to these questions by obtaining background checks and license verifications as applicable.

You will be notified of any resulting issues within two (2) business days after all reports are received. INHS will make a copy of the report available to you upon your request.

**1. Have you lived outside the state of Washington?** No \_\_\_\_ Yes \_\_\_\_

If yes, list all previous counties with their states where you have lived, or other countries:

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**2. Have you ever been convicted of a crime?** No \_\_\_\_ Yes \_\_\_\_

If yes, please identify the offense(s), provide the date(s) of the conviction(s), the name of the court and the sentence(s) imposed:

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**3. Have you ever had findings made against you for domestic violence, abuse, sexual abuse, neglect, exploitation or financial exploitation of a child or a vulnerable adult in any civil adjudicative proceeding?** (Civil adjudicative proceeding includes judicial or administrative proceedings as well as findings by DSHS or the Department of Health that you have not administratively challenged or appealed). No \_\_\_\_ Yes \_\_\_\_

If yes, please identify the specific finding(s), which agency or court made the finding(s), the date(s) of the finding(s) and the penalty(ies) imposed:

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**4. Have you ever had findings made against you would exclude you from participation in Medicare, Medicaid and other Federal Health Care Programs?** No \_\_\_\_ Yes \_\_\_\_

If yes, please identify the offense(s), provide the date(s) of the conviction(s) imposed:

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Inland Northwest Health Services may request your fingerprints to obtain from the criminal identification systems a report of your record of criminal convictions for offenses against person, civil adjudications of child abuse, and disciplinary board final decision.

I declare under the penalty of perjury under the laws of the State of Washington that the foregoing is true and correct. I understand that if I am hired, or allowed to participate in any of our programs/classes, I can be discharged for any misrepresentation or omission in the above statement. I also understand that if hired or allowed to participate in any of our programs/classes, my employment/acceptance into the program/class is conditioned on satisfactory results of all background checks.

I hereby authorize INHS to obtain background checks and license verifications as applicable at any time during my employment/contract/volunteer service/student.

Name (Print): \_\_\_\_\_ Alias/Maiden: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_