

May 23, 2024

Dear Prospective Paramedic Student,

Thank you for your interest in the Doña Ana Community College Emergency Medical Services Paramedic Program. Enclosed is the application for the upcoming 2024-2025 Paramedic program, as well as a description of the Paramedic Certificate and Associate Degree Program.

**Pre-requisite courses** will begin August 21, 2024. You are encouraged to register and complete the pre-requisite courses this fall. You may complete the classes prior to admission to the program. The pre-requisite classes are listed below. Please contact Nicole Marcak and she can assist you with registration.

CRN #	Subject	Crs	Sec	Credit hours	Title	Days	Time	Type	Dates
47385	OEEM	201	D01	3	<u>Human Systems, Pathophysiology and Development</u>	TWR	0830-1630	Online with In Person Mtgs	8/21-9/10
47386	OEEM	206	D01	3	<u>Introduction Paramedic Practice</u>	TWR	0830-1630	Online with In Person Mtgs	9/11-10/1
47388	OEEM	207	D01	2	<u>Emergency Pharmacology</u>	TW	0830-1430	Online with In Person Mtgs	10/2-10/22
47387	OEEM	207 L	D01	1	<u>Emergency Pharmacology Lab</u>	R	0830-1630	Lab – In person	10/2-10/22

**Application Process** In order to apply to the program, you must submit the following **before June 21, 2024 as a completed packet**. Any application that is not complete will not be considered by the committee. Late applications will not be evaluated until after the applications received prior to the deadline have been fully reviewed. Due to space limitations the course is limited to 8-16 students.

**To the EMS Department**

1. **A copy of your current New Mexico EMT-Basic or EMT-Intermediate License.**
2. **A copy of your current CPR card, Hazmat Awareness Certificate, ICS 100, ICS 700 and Course Completion Certificate.** (If you do not have proof of attending a hazmat awareness you will be required to complete the required online course prior to admission to the program)
3. **A letter of intent.** This letter should be addressed to the EMS Department Director and discuss the reasons why you would like to be considered for entry into the program.
4. **A typed resume.**
5. **A completed medical history form** (this form is **not** to be done by a physician, it is a general form to be filled out by the student.)
6. **Three letters of recommendation.** These letters should address your qualities, strengths, ethics, and other related factors that can attest to your suitability for EMT-P training and should not be from your family members. These letters should be from instructors, employers, or someone who can evaluate your performance potential.
7. **Copy of all Transcripts.** The college will require official transcripts; we will accept copies.
  - a. The transcripts must show that you have successfully completed the three prerequisite courses and obtained a “C” or better (OEEM 201, OEEM 206, OEEM 207 and 207L) if completed in the past. If you are taking the classes this spring you will need to earn a “C” or better to continue in the program.

**To DACC Admissions Office:**

- 1) Completed DACC application form with appropriate admission fee. If you are currently a student, or past student at DACC, this may not be necessary.
- 2) Official high school and college transcripts or GED test scores e-mailed directly to the DACC Admissions office, if you have never been a student at DACC.

All candidates will receive, in writing, the result of the preliminary review of their application and the contact time and date to arrange for the final pre-screening criteria will be given to the students who are eligible.

Written Entrance

Committee Interview

The Written Exam and Committee Interview will be scheduled individually and concluded before **July 15, 2024**. Exams will be conducted on Zoom. We are planning to conduct interviews in person. Candidates who have successfully met the entrance requirements will be notified of date and time of their interview.

Please use this link to register for the Exam **[EXAM REGISTRATION](#)**

All candidates who have met the minimum requirements for the EMT-Paramedic Program will be contacted in writing. The department will take the top 8-16 ranked candidates. There will be an alternative list in case of withdrawals. There will be a program orientation for all qualified candidates followed by a social for the candidates and their significant others. This meeting will cover all of the requirements of the program, as well as the college resources, scholarship/grant information and give you the opportunity to ask any questions before committing to the program. Please do not hesitate to call the EMS Department if you have further questions or concerns. The phone number is 575-528-7411.

Sincerely,

***Ann***

Ann Bellows, EdD, NRP, RN  
Program Director  
Emergency Medical Services Department

2024-2025 Cohort – Course Schedule

Start Date- 8/21/2024

End Date – 12/12/2024

Start Date	End Date	Course Number	Course Name
Fall 2024			
8/21/2024	9/10/2024	OEEM 201	Human Pathophysiology – Pre Requisite
9/11/2024	10/1/2024	OEEM 207	Introduction to Pharmacology – Pre Requisite
9/11/2024	10/1/2024	OEEM 207L	Introduction to Pharmacology Lab – Pre Requisite
10/2/2024	10/22/2024	OEEM 206	Introduction to Advanced Prehospital Care – Pre Requisite
10/23/2024	11/12/2024	OEEM 210	Cardiac Rhythm Interpretation
11/13/2024	12/12/2024 Extra Day for ACLS	OEEM 212	EMT-Paramedic Cardiovascular Emergencies
Spring 2025			
1/15/2025	2/4/2025	OEEM 202	EMT-Paramedic Respiratory Emergencies
1/15/2025	2/4/2025	OEEM 202	EMT-Paramedic Respiratory Emergencies
2/5/2025	2/25/2025	OEEM 213	EMT-Paramedic Medical Emergencies I
2/26/2025	3/27/2025 + 1 8 hour day 2 for AMLS	OEEM 214	EMT-Paramedic Medical Environmental Emergencies II
4/1/2025	5/10/2025 + 2 8 hour days for PALS and NRP	OEEM 216	EMT-Paramedic Reproductive/Childhood Emergencies
3/6/2025	5/10/2025	OEEM 240	EMT-Paramedic Field I
Summer 2025			
5/15/2025	6/4/2025 + 8 hour day for PHTLS	OEEM 203	EMT-Paramedic Trauma Emergencies
5/15/2025	6/4/2025	OEEM 203 L	EMT-Paramedic Trauma Emergencies Lab
6/10/2025	7/10/2025	OEEM 230	EMT-Paramedic Clinical I
Fall 2025			
8/20/2025	9/18/2025	OEEM 231	EMT-Paramedic Clinical II
8/20/2025	10/16/2025	OEEM 241	EMT-Paramedic Field II
10/20/2025	12/12/2025	OEEM 242	EMT-Paramedic Field Internship
10/20/2025	12/12/2025	OEEM 243	EMT-Paramedic Preparation for Practice

# Medical History Form

Last Name	First	MI	Sex	Date of Birth	Social Security Number
Local Address (No. and Street)		City	State	Zip	Telephone Number
Place of Birth	Job Title	Department or Unit		Supervisor	Dept./Unit Phone
Emergency Contact	Telephone	Personal Medical Provider		Telephone	

## Personal Health History

Have you EVER HAD, or do you have, any of the following? Check EACH item. If yes, specify by number and explain:

- |   | No                       | Yes                      |                                       | No                       | Yes                      |
|---|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|
| 1. Chicken pox or shingles                | <input type="checkbox"/> | <input type="checkbox"/> | 25. Broken bones                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Measles                                | <input type="checkbox"/> | <input type="checkbox"/> | 26. Bone or joint problems            | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Mumps                                  | <input type="checkbox"/> | <input type="checkbox"/> | 27. Arthritis/gout                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Skin problems or chronic rash          | <input type="checkbox"/> | <input type="checkbox"/> | 28. Back pain/injury                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Eye problems                           | <input type="checkbox"/> | <input type="checkbox"/> | 29. Numbness/tingling legs or feet    | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Hearing loss or ear problems           | <input type="checkbox"/> | <input type="checkbox"/> | 30. Knee pain/injury                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Chronic cough                          | <input type="checkbox"/> | <input type="checkbox"/> | 31. Foot pain/injury                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Asthma                                 | <input type="checkbox"/> | <input type="checkbox"/> | 32. Neck pain/injury                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Shortness of breath                    | <input type="checkbox"/> | <input type="checkbox"/> | 33. Loss of limb                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Lung problems                         | <input type="checkbox"/> | <input type="checkbox"/> | 34. Severe headaches                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Tuberculosis or positive TB skin test | <input type="checkbox"/> | <input type="checkbox"/> | 35. Dizziness or fainting             | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Chest pain                            | <input type="checkbox"/> | <input type="checkbox"/> | 36. Epilepsy or seizures              | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Heart trouble/attack                  | <input type="checkbox"/> | <input type="checkbox"/> | 37. Severe weakness or tiredness      | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Palpitations/irregular heart beat     | <input type="checkbox"/> | <input type="checkbox"/> | 38. Depression or anxiety             | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Heart murmur                          | <input type="checkbox"/> | <input type="checkbox"/> | 39. Emotional or psychiatric problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. High blood pressure                   | <input type="checkbox"/> | <input type="checkbox"/> | 40. Drug or Alcohol dependency        | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Stroke or paralysis                   | <input type="checkbox"/> | <input type="checkbox"/> | 41. Eating disorder                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Stomach or intestinal problem         | <input type="checkbox"/> | <input type="checkbox"/> | 42. Bleeding or blood disorder        | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Liver disease/hepatitis               | <input type="checkbox"/> | <input type="checkbox"/> | 43. Immune suppression                | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Kidney disease                        | <input type="checkbox"/> | <input type="checkbox"/> | 44. Chronic/recurrent infection       | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Weight change                         | <input type="checkbox"/> | <input type="checkbox"/> | 45. Tumor/cancer                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Thyroid problems                      | <input type="checkbox"/> | <input type="checkbox"/> | 46. Anemia                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Shoulder/elbow/wrist/hand pain        | <input type="checkbox"/> | <input type="checkbox"/> | 47. Diabetic                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Numbness/tingling of arms or hands    | <input type="checkbox"/> | <input type="checkbox"/> | 48. Any other illness not listed      | <input type="checkbox"/> | <input type="checkbox"/> |

*Continues on next page*

**Habits and Questions Related to Work**

Please Check Each Item, If YES, specify by number and explain:

- |   | No                       | Yes                      |   | No                       | Yes                      |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Are you on any medications . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you have visual, hearing or other physical limitations : . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any allergies to medication . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | 13. Are you unable to assume any normal body positions . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you use other drugs . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | 14. Are you unable to perform certain motions . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you use alcohol . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | 15. Is there any reason you cannot fully perform all duties that your employment or volunteer work will require on any shift. . . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Refused as a blood donor . . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | 16. Have you ever had a work related injury or illness. . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you smoke cigarettes . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | 17. Have you ever had:  |                          |                          |
| 7. Have you ever been hospitalized . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> | a) needlestick/blood or body fluid exposure. . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had surgery. . . . .   | <input type="checkbox"/> | <input type="checkbox"/> | b) rash or symptoms related to glove use. . . . .   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever received treatment or counseling for psychiatric or emotional illness . . . . .                          | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 10. Do you have allergies to certain chemicals, dust, animals, or animal products (animal dander, bedding waste). . . . . | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 11. Have you ever been refused employment for health reasons . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

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List physicians or other health care providers you have seen in the past three years:

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 I understand that any offer of employment is contingent upon my ability to perform, with reasonable accommodation if necessary, the duties for the position based on medical examination and any other information necessary to determine medical clearance for employment. Such examination is consistent with business necessity and requires that determination be made that you do not pose a risk to patients, co-workers or others individuals in the workplace.

I certify that the information documented on this form is **true and complete** to the best of my knowledge. I understand that misrepresentation or omission of facts may prevent my employment or may be cause for termination after beginning employment.

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Name (Print) \_\_\_\_\_ Name (Signed) \_\_\_\_\_ Date \_\_\_\_\_

## Study Guide for Paramedic Entrance Exam

In order to prepare for the upcoming entrance examination the following is a list of topics the candidate should review.

1. Medical/Legal
2. Patient Assessment - the steps and process.
3. Medical Terminology
4. Assessment requirements for the following specific systems:
  - Cardiovascular
  - Respiratory
  - Airway
  - Abdominal
5. Environmental emergencies
6. Medical emergencies
7. Trauma emergencies
  - bleeding control and shock
  - pathophysiology of head injuries.
8. Pediatric emergencies
9. Emergency childbirth
10. Procedures for ventilation of adults and pediatrics
11. Implications of changes in vital signs to include pulse, blood pressure and respirations
12. Patient Documentation
13. Pathophysiology of shock
14. Procedure Guidelines, Scope of Practice and the Treatment Guidelines located on the EMS Bureau webpage ([www.NMEMS.org](http://www.NMEMS.org))

**You must obtain an 80% on both your written and practical skills in order to be eligible for the paramedic program.**

# PATIENT ASSESSMENT MEDICAL/TRAUMA to meet state skill requirements

Candidate: \_\_\_\_\_ Date: \_\_\_\_\_ Pass Fail Retake

Skill Evaluator: \_\_\_\_\_ Scenario #: \_\_\_\_\_

Time Start: \_\_\_\_\_ Station #: \_\_\_\_\_

Takes/verbalizes body substance isolation precautions prior to administration (PPE,BSI)		1			
<b>SCENE SIZE UP</b>					
Determines if the scene is safe		1			
Determines the mechanism of injury		1			
Determines the number of patients		1			
Requests additional help if necessary		1			
Considers stabilization of the spine		1			
<b>INITIAL ASSESSMENT</b>					
Verbalizes general impression of the patient (first contact)		1			
Determines responsiveness/level of consciousness		1			
Determines chief complaint/obvious life threats		1			
Assesses airway and breathing	*Assessment	1			
Treat as needed	*initiate appropriate oxygen therapy	1			
	*Assures adequate ventilation	1			
	*injuries/illness management	1			
Assesses circulation	*Assesses and controls major bleeding	1			
Treat as needed	*Assesses central and peripheral pulses	1			
	*Assesses skin color, temperature, condition	1			
Expose needed areas		1			
Identifies priority patients and makes transport decision		1			
<b>FOCUSED HISTORY AND PHYSICAL EXAMINATION</b>					
Selects appropriate assessment (focused or rapid assessment) treat as needed		1			
Obtains baseline vital signs (Resp. Pulse (quality, regularity, rate) B/P, Pulse Ox, BGL		5			
Obtains SAMPLE/OPQRSTU history treat as needed		1			
<b>DETAILED PHYSICAL EXAM</b>					
Assess the head	*Inspects and palpates the scalp and ears	1			
Treat as needed	*Assesses the eyes	1			
	*Assesses the facial areas (nose, mouth, etc....)	1			
Assess the Neck	*Inspects and palpates the neck	1			
Treat as needed	*Assesses of JVD	1			
	*Assesses for tracheal deviation	1			
	*Posterior Cervical	1			
Assess the chest (may be included In the initial assessment)	*inspects	1			
Treat as needed	*palpates	1			
	*Auscultates Breath Sounds	1			
Assess the abdomen/pelvis (may Be included in the initial assessment)	*Assesses the abdomen	1			
Treat as needed	*Assesses the pelvis	1			
	*Assesses ge	1			
Assesses the extremite (lower Extremities may be included in the Initial assessment)	*upper extremities	1			
Treat as needed	*Lower extermities	1			
	*Inspect and palpate for Pulses, Movement, Sensation	3			
Assess the posterior	*Assesses the back of the head	1			
Treat as needed	*Assesses the thoracic spine and chest	1			
	*Assesses the lumbar spine and flanks	1			
Manages secondary injuries/illness appropriately		1			
Verbalizes reassessment		1			

Time End: \_\_\_\_\_

TOTAL 48 \_\_\_\_\_

## **CRITICAL CRITERIA on the back**

Medical First Responder –Paramedic

updated 5/2/2018

**CRITICAL CRITERIA (5 points will be deducted from total score for each critical criteria checked)**

- \_\_\_\_\_ Did not determine scene safety
- \_\_\_\_\_ Did not assess for spinal protection
- \_\_\_\_\_ Did not provide spinal protection when indicated
- \_\_\_\_\_ Did not provide adequate oxygen therapy
- \_\_\_\_\_ Did not find or manage problems associated with the airway, breathing, hemorrhage or shock
- \_\_\_\_\_ Did not differentiate the patient's need for transportation versus continued assessment at the scene
- \_\_\_\_\_ Did not do other detailed physical examination or treatment before assessing and treating problems associated to with airway, breathing, circulation.
- \_\_\_\_\_ Did not complete patient assessment or treatment within the 10 minute time limit
- \_\_\_\_\_ Did not transport the patient within 10 minute time line
- \_\_\_\_\_ Performs any action or uses any equipment in a dangerous or inappropriate manner
- \_\_\_\_\_ Failure to function as a competent EMT
- \_\_\_\_\_ Exhibit unacceptable affect with patient or other personnel
- \_\_\_\_\_ Did not score more than 38 points

**COMMENTS:**



Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Grading Matrix

Grading will be based on candidate’s performance during the interview, skills evaluation, written evaluation, resume, and letters of recommendation. The tool will be used for evaluation.

Performance on topic evaluated

0 = was either inappropriate, did not apply to the topic at all, or was not addressed by the candidate or supporting documentation.

1 = was rudimentary or minimally addressed by the candidate or supporting documentation.

2 = was well thought out and showed understanding of topics through candidate performance or supporting documentation.

Question #	Topic	Weight	Point Value	Total Point Value
<b>Example</b>	<b>Mission Statement</b>	<b>2</b>	<b>1</b>	<b>2</b>
1	Field of EMS	1		
2	Leadership	2		
3	Educational Experience	2		
4	Task Performance	2		
5	Decision Making	2		
6	Challenge to Completion of Program	3		
7	Dealing with People	3		
8	Stress Management	2		
9	Ethics Scenario	3		
10	Field of Paramedicine	2		
11	Negative Feedback	3		
12	Ethics	3		

Please score the candidate on the following characteristics:

Professionalism:

Poor (-5)      Needs Improvement (-2)      Acceptable      Excellent (+5) \_\_\_\_\_

Communication (verbal / non-verbal)

Poor (-10)      Needs Improvement (-5)      Acceptable      Excellent (+10) \_\_\_\_\_

The thing that especially impressed me with this candidate was.....

The thing that least impressed me with this candidate was.....

Signature of Evaluator \_\_\_\_\_

Total Points \_\_\_\_\_ /71 Max