ST. LAWRENCE COUNTY EMERGENCY SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES

EMT TRAINING SCHOLARSHIP APPLICATION

Please read this application carefully and in its entirety, as failure to complete as written may result in the rejection of your scholarship application.

Thank you for your interest in becoming a certified EMT!

The St. Lawrence County Emergency Services Bureau of Emergency Medical Services (SLCBEMS) Training Scholarship was created in conjunction with the St. Lawrence County Board of Legislators to assist our community members in becoming EMT's by fully or partially sponsoring the tuition of the EMT course. This scholarship gives priority to those currently affiliated with a New York State Department of Health recognized EMS agency, and is designed to help departments who are in need of financial assistance get their members fully certified to the EMT level.

CHECKLIST AND INSTRUCTIONS:

[ ]	Meet the requirements for the scholarship. Requirements: **NONE**
[ ]	Locate an EMT course in your area. Most St. Lawrence County courses can be found at: https://www.clarkson.edu/ems-course-certification.
[ ]	Complete the attached scholarship application, including (if applicable) having the agency leader complete SECTION THREE.
[ ]	Submit the completed application in person (**DO NOT MAIL**) to: 49 ½ Court Street, Emergency Services Canton, NY 13617 **OR** By Email: mdenner@stlawco.gov

Following the receipt of this application, you shall receive correspondence by email or phone within **two business days** regarding the award of the scholarship. In the event that there is no communication within this timeframe, please contact the SLCBEMS office at (315)379-2240.

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SECTION ONE: DEMOGRAPHICS			
Are you currently affiliated with a NYS EMS agency?: ( ) YES ( ) **NO ***If no, you must complete SECTION FOUR of this application. If yes, you do not need to complete SECTION FOUR***			
Full Name:			Date of Birth:
Address:			
City/Town:	State:	Zip:	Phone:
Email:			
Have you ever been an EMT?: ( ) YES ( ) NO		If yes, when and EMT number:	
Are you a Clarkson student?: ( ) YES ( ) NO		If yes, CU Student Number:	

SECTION TWO: COURSE INFORMATION/MATERIALS	
Requested course location and dates:	Requested course Instructor:
Are you requesting financial assistance for a textbook? ( ) YES ( ) NO If yes, book _____	Are you requesting financial assistance for uniforms? ( ) YES ( ) NO
****If requesting financial assistance for a textbook/uniform, if approved, you shall receive 90% of the total cost up front, with the remaining 10% reimbursed after receipts are submitted to SLCBEMS****	

SECTION THREE: AGENCY INFORMATION	
Please fill out this section if you are currently affiliated with a DOH-recognized agency. If you are not affiliated with a DOH-recognized agency, leave this section blank.	
Agency Name:	Agency Code:
Agency Leader and Title:	
Agency Leader Phone:	Agency Leader Email:
I, as an official representative of the NYS EMS agency listed above, affirm that the applicant named in SECTION ONE of this form is a member in good standing of the listed NYS EMS service. I also understand that SLCBEMS may contact me for additional information, and that SLCBEMS will request the reimbursement funds that the applicant's agency receives through NYS DOH once the student successfully passes the course. I also understand that the student must complete the entirety of the course or this scholarship may be revoked.	
_____ Agency Official's Signature	_____ Date

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SECTION FOUR: CHARACTER REFERENCE	
Please fill out this section **only if you are not affiliated with an NYS EMS agency**. Please note that this reference will be considered part of the application for the St. Lawrence County Emergency Services Bureau of EMS EMT-B Training Scholarship only, and shall be considered confidential when received. Most reference requests are sent via email unless otherwise specified.	
Reference Name:	
Reference Phone:	Reference Email:
Relationship to Reference:	Years known:

SECTION FIVE: ADDITIONAL INFORMATION
In a few sentences, please explain why you wish to be an EMT:

SECTION SIX: ATTESTATION
I, _____, understand that I am applying for the St. Lawrence County Emergency Services Bureau of Emergency Medical Services (SLCBEMS) EMT-B Training Scholarship and affirm my wish to be considered as a nominee for this scholarship. I have read and understand this application in its entirety, understand that this application must be reviewed and approved by SLCBEMS staff, and that any agency affiliations I list may be contacted for a character reference. I understand that if I am not affiliated with an EMS agency, my reference listed in SECTION FOUR will be contacted for a character reference, and such character reference will be considered confidential. I understand that priority for this scholarship will be given to those affiliated with a DOH recognized EMS agency. I understand that if awarded this scholarship, I must complete the EMT-B course and pass the EMT-B certification exam, and that if I am unaffiliated with an EMS agency at the time of award, I must work or volunteer in a first-responder capacity for a minimum of one (1) year in St. Lawrence County following certification. I attest that I have reviewed NYS DOH Part 800.6 and am eligible to be certified as a NYS EMT-B. I understand that failure to meet the guidelines as stated in this section may result in revocation of this scholarship, and that repayment to SLCBEMS in full will be required.
_____ Applicant Signature _____ Date

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SECTION SEVEN: SLCBEMS STAFF USE ONLY

I, _____, have reviewed this application in its entirety, and hereby _____ this application.
Approve/Deny

_____ _____
Staff Signature & Title Date