



April 2022

*EMT - Paramedic  
Program - CMA  
Advanced Care  
Paramedic*

Dear Potential FMR Student:

**RE: First Medical Responder Program**

*EMT - CMA  
Primary Care  
Paramedic  
and EMR,  
Programs*

Thank you for your interest in our FMR course. Please find enclosed some information regarding the next available course, as well as an application form. Courses are filled on a first-come, first-served basis, and we are currently accepting registrations for the next available course.

*First Aid, CPR  
and MFR,  
Programs - Needs  
Assessment and  
Training*

The next course is scheduled to begin on **Tuesday May 24<sup>th</sup>, 2022 at 1800h**. The course will be held from 1800h – 2200h, and includes 2 weekend sessions comprised of a Friday night and full days Saturday and Sunday and 1 weekend comprised of Saturday and Sunday.

*Educational  
Seminars and  
Workshops*

The course will be run from our office in St. Albert. The cost of the course is \$2,185.00 including GST and includes the costs of the manual, course textbook, study exercises and handouts.

*Training  
Assessment,  
& Consulting*

The First Medical Responder program includes a driving program including both didactic time, as well as a high-fidelity driving simulator, and includes a CPR - Health Care Provider update for all students. Graduates are eligible to apply to our Primary Care Program.

*Interactive  
Multi-Media*

Please contact the office if you require more information or specific details. Enclosed with the application form, payment can be made with Cash, Cheque, Visa, MasterCard, Debit or Money order returned to the office.

*Advanced Driving  
Simulation  
Program*

Our complete mailing address is:

**Professional Medical Associates**

#101, 265 Carleton Drive  
St. Albert, Alberta T8N 4J9

*On-site Program  
Delivery  
Specialists*

**Due to COVID-19 PLEASE mail or email your applications to the office. Do not come to the office in person. Thanks for your understanding.**

*Paramedical and  
EMS staffing*

You may also contact the office via email at the following address: [larissa@pmawebsite.net](mailto:larissa@pmawebsite.net)

*Pediatric Education  
for Prehospital  
Professionals,  
Geriatric Education  
for Emergency  
Medical Services*

Thank you again for your interest, and we look forward to seeing you at our next course.

Sincerely,

**PER: Professional Medical Associates**

James Habstritt, ACP, B.H.Sc.  
Program Director

*ACLS, PALS and  
PHTLS*

JH/



# PROGRAM APPLICATION FORM

**Application for: (check one)**

*EMT-Paramedic Program - CMA Advanced Care Paramedic*

*Educational Seminars and Workshops*

*EMT- CMA Primary Care Paramedic and EMR Programs*

*First Aid, CPR and AED Programs - Needs Assessment and Training*

*Training Assessment, & Consulting*

*Interactive Multi-Media*

*High-Fidelity Simulator/Driving Programs*

*On-site Program Delivery Specialists*

*Paramedical and EMS staffing*

*Pediatric Education for Prehospital Professionals, Geriatric Education for Emergency Medical Services, PHALS, TECC, PALS and ACLS*

<input type="checkbox"/> First Medical Responder (FMR/EMR1)* <input type="checkbox"/> Emergency Medical Responder+ <input type="checkbox"/> EMR Refresher Program* <input type="checkbox"/> Primary Care Paramedic (EMT)+ <input type="checkbox"/> PCP (EMT) Refresher Program* <input type="checkbox"/> Advanced Care Paramedic (EMT-P)+	<input type="checkbox"/> ACP (EMT-P) Refresher Program* <input type="checkbox"/> Fundamentals of Airway - Basic* <input type="checkbox"/> Difficult Airway Course - Advanced* <input type="checkbox"/> BLS for Health Care Professional (CPR)* <input type="checkbox"/> ACLS* or <input type="checkbox"/> PALS* for DDS <input type="checkbox"/> Other (specify): _____
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<b>LEGAL SURNAME</b>		<b>FIRST NAME/MIDDLE INITIAL</b>	
<b>ADDRESS</b>			
<b>CITY/TOWN</b>		<b>PROVINCE</b>	<b>POSTAL CODE</b>
(    )		(    )	(    )
<b>PHONE (HOME)</b>		<b>PHONE (BUSINESS)</b>	<b>PHONE (MOBILE)</b>
<b>DATE OF BIRTH (MM/DD/YY)</b>		<b>DRIVER'S LICENCE #</b>	<b>EMPLOYER/POSITION</b>
<b>PREVIOUS EMS TRAINING INSTITUTION (If Applicable)</b>			<b>GRADUATION DATE</b>
<b>EMAIL ADDRESS</b>			<b>ACP REGISTRATION #</b>

**FOR OFFICE USE ONLY:**

<b>AMOUNT PAID: \$</b> _____ MC    Visa    Debit    Cash    Chq #    Other Authorization # _____ Security # _____ Invoice or PO# _____	<b>COURSE CODE:</b> _____ <b>START DATE:</b> _____	<b>CONFIRMATION LETTER:</b> <b>Sent or P/U (SF) (MC)</b> <b>Date:</b> _____ <b>COMMENTS:</b> _____
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**\*PLEASE NOTE - UPON COMMENCEMENT OF PROGRAM, FEES WILL NOT BE REFUNDED.\***

**\*FOR EMR, PCP AND ACP PROGRAMS - TUITION REFUNDS OF LICENSED PROGRAMS ARE GUIDED BY THE PRIVATE VOCATIONAL TRAINING REGULATION AS OUTLINED ON EXECUTION OF STUDENT CONTRACT.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_