# Simulation request form

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| **Contact Name:** | | | |  | | | | | | **Phone Number:** | | | | | | |  | | | | | | |
| **Lead Educator:** | | | |  | | | | | | **Date of request completion:** | | | | | | | |  | | | | | |
| **Title:** | | | |  | | | | | | **Cost Center:** | | | | | | |  | | | | | | |
| **Department:** | | | |  | | | | | | Entity: | | | | | LLU  MC  CH  HS  SS | | | | | | Other: | | |
| **Please list additional Faculty/Educators/Instructors**  All educators, faculty, and/or instructions teaching simulation at the Medical Simulation Center must have attended the Educator Training/Methodology Course provided by the MSC. | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | |  | | | | | | | | | | **Title:** | | | |  | | | | | | | |
| **Name:** | |  | | | | | | | | | | **Title:** | | | |  | | | | | | | |
| **Name:** | |  | | | | | | | | | | **Title:** | | | |  | | | | | | | |
| **Name:** | |  | | | | | | | | | | **Title:** | | | |  | | | | | | | |
| **MSC Staff Required:** | | | | | **Yes  No** | | | | | **Number of MSC Staff Required:** | | | | | | | | |  | | | | |
| **Course Name:** | | |  | | | | | | | | | | **Number of learners:** | | | | | |  | | | | |
| **DATES AND TIMES REQUESTED FOR SIMULATION** | | | | | | | | | | | | | | | | | | | | | | |
| **please provide requested dates and times** | | | | | | **start time** | **end time** | | **please provide requested dates and times** | | | | | | | | | | | **start time** | | **end time** |
| Date: |  | | | | |  |  | | Date: | | | | |  | | | | | |  | |  |
| Date: |  | | | | |  |  | | Date: | | | | |  | | | | | |  | |  |
| Date: |  | | | | |  |  | | Date: | | | | |  | | | | | |  | |  |
| Date: |  | | | | |  |  | | Date: | | | | |  | | | | | |  | |  |
| **Dates and times special note** | | | | | | | | | | | | | | | | | | | | | | |
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| **Research** | | | | | | | | | | | | | | | | | | | | | | | |
| Do you plan to collect data from this session:  **Yes  No**  Do you plan to use the data for Research/Publication: **Yes  No**  IRB Approval: **Yes  No  Pending**  Primary Investigator: School/Department: Ext. | | | | | | | | | | | | | | | | | | | | | | | |
| **BY SIGNING THIS FORM, I UNDERSTAND AND AGREE TO ALL OF THE FOLLOWING STIPULATIONS:**  * EVERY ITEM MUST BE COMPLETED AT LEAST TWO WEEKS PRIOR TO THE FIRST SESSION. * ALL LEARNERS MUST ATTEND IN WORK UNIFORM. * EVALUATIONS NEED TO BE COMPLETED BY EACH LEARNER AT THE END OF EACH SESSION. * an MSC agreement letter and IRB APPROVAL are required prior to collecting data for research. Please contact the MSC Research Office at x82220.   **FURTHEMORE, I ACKNOWLEDGE THAT IF ANY OF THE ABOVE REQUIREMENTS ARE NOT MET AS AGREED UPON,**  **THE SIMULATION WILL BE CANCELED.** | | | | | | | | | | | | | | | | | | | | | | | |
| **LEAD EDUCATOR PRINT NAME:** | | | | | | | | **LEAD EDUCATOR Signature:** | | | | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | | | |
| DATE: | | |  | | | | | | | | | | | | |

Thank you for completing the Simulation Request Form!

We look forward to working with you. Please feel free to contact us if you have any questions.

Email: [simulationcenter@llu.edu](mailto:simulationcenter@llu.edu) Telephone: 909-558-7208 Fax: 909-558-0967

**MSC STAFF COMPLETE THIS PAGE ONLY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| MSC EDUCATOR NAME: |  | | DATE OF MEETING: |  |
| EVALUATION NEEDED: | ANIMATED | IMMERSIVE | COMPETENCY | NOT REQUIRED |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Learning objectives** | | | | | | | | | | |
|  | | | | | | | | | | |
| **simulation scenarios**  Scenarios/agendas must be received one month prior to each session, or the simulation session(s) will be cancelled. | | | | | | | | | | |
|  | | | | | | | | | | |
| **SIMULATION ROOMS AND EQUIPMENT** | | | | | | | | | | |
| # of Simulated Environments Requested: | | | |  | | # of Debriefing Rooms Requested: | | |  | |
| # of Manikins Requested: | |  | | **SELECT DESIRED MANIKINS BELOW** | | | | | | |
| ADULT | BIRTHING | | 5 YEAR OLD | | PREMIE | | 1 YEAR OLD | INFANT | | NEWBORN |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ADDITIONAL INFORMATION | | | | | |
|  | | | | | |
| DATE RECEIVED: |  | APPROVAL DATE: |  | MSC CALENDAR | CONFIRMATION |

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| **DATES AND TIMES REQUESTED FOR SIMULATION**  A dry run of any new scenario must be completed at least 2 weeks before the first schedule | | | | | | | | | | | |
| **dry run date:** | |  | | | **dry run start time:** | |  | **dry run end time:** | |  | |
| **confirmed dates and times** | | | **start time** | **end time** | **confirmed dates and times** | | | | **start time** | | **end time** |
| Date: |  | |  |  | Date: |  | | |  | |  |
| Date: |  | |  |  | Date: |  | | |  | |  |
| Date: |  | |  |  | Date: |  | | |  | |  |
| Date: |  | |  |  | Date: |  | | |  | |  |
| **Dates and times special note** | | | | | | | | | | | |
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