# 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** |
|  |
| **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 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** |
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| **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 |

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| 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** |
|  |