# **ECU Brody School of Medicine**

# **Interprofessional Clinical Simulation Center**

# **Request Form**

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| --- | --- |
| **Today’s Date:** Select Date |  |
| **Session Title:** |  |
| **Course Facilitator, Dept., email & Phone #** |  |
| **Brief course description** |  |
| **Educational objectives** |  |
| **Date of session** | Select Date Select Date Select Date Select Date Select Date |
| **Date of session** | Select Date Select Date Select Date Select Date Select Date |
| **Date of session** | Select Date Select Date Select Date Select Date Select Date |
| **Session start & end time(s)** |  |
| **# Of high-fidelity simulator rooms needed\*** |  |
| **# Of task trainer skills rooms needed\*** |  |
| **Large meeting/classroom/training room needed (Brody Commons, Auditorium, etc.)?** |  |
| **Total # of participants** |  |
| **# Of groups/stations:** |  |
| **Types of high-fidelity simulators** | Choose an item. Choose an item. Choose an item. Choose an item. |
| **Types of skills task trainers** | Choose an item. Choose an item. Choose an item. Choose an item. |
| **Additional medical equipment needed** **(crash cart, defibrillator, etc.)** |  |
| **Will you need live simulation patient/s?** |  |
| **Will you be bringing any equipment?** **If yes, what will you be bringing?** |  |
| **Do you want to record your session?** |  |
| **FOR HIGH FIDELITY SIM REQUESTS ONLY** |  |
| **Scenario already developed/previously used? If yes, name/title (First 5 Minutes, etc.)** |  |
| **Scenario walk through/rehearsal date (1-2 weeks prior to date of session, required prior to 1st session.)** |  |
| **Do you require a simulation specialist /technician?** |  |
| **Do you require preprogramming of the high fidelity scenario by a simulation specialist** **If yes, all information with vitals must be provided to simulation center a minimum of 2 weeks prior to course date** |  |
| **Off-Site use request (In situ Simulation)** |  |
| **Off-Site use location (In situ Simulation)** |  |
| **Off-Site departmental pick-up date** | Click here to enter a date. |
| **Off-Site departmental return date** | Click here to enter a date. |
| **Comments (Additional dates, room preferences, special needs, etc.)** |  |

Please email completed form to [csc@ecu.edu](mailto:csc@ecu.edu).

**\*Rooms will be assigned based on availability and room requirements**

CSC Request Form version 6-14-21

**Below is our expected timeline for all sessions through the simulation program. Please contact us if you have any** **questions**.

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| --- | --- | --- | --- | --- |
|  | New Courses | Recurring/Established Courses | Healthcare Simulation Unit/Osprey | Equipment Loan/In Situ\* |
| CSC Request Form | 4 weeks prior to course date | 4 weeks prior to course date | 5 weeks prior to course date | 4 weeks prior to course date |
| In-Person Meeting with CSC Staff | 3 weeks prior to course date | 3 weeks (if changes planned) or 1 week to specify skills prior to course date | 3 weeks prior to course date | 3 weeks prior to course date |
| Programming and/or Standardized Patient Requests | 2 weeks prior to course date | 2 weeks prior to course date | 2 weeks prior to course date | 2 weeks prior to course date |

\*See Equipment Procedures in User Guide