Request Form

Today's Date: __/__/__

Name: ___________________________ Title: ___________________________

Phone #: (___) ___ - ____ Fax #: (___) ___ - ____ Alternate Phone #: (___) ___ - ____

Email Address: ___________________________

College/Department: ___________________________ Program: ___________________________

(duration)

(list dates on the back of this form)

Please Note: If this is the first time using the requested equipment at the Center for Healthcare Simulation an orientation session must be scheduled prior to use.

Brief description of use of Simulation Lab

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Return request via email or fax to:
Jennifer Brown-Charles
Administrator, Center for Healthcare Simulation
(718) 270-7633 (phone)
(718) 270-7471 (fax)
chsimulation@downstate.edu
<table>
<thead>
<tr>
<th>Date</th>
<th>Activity Name</th>
<th>Faculty</th>
<th>Time</th>
<th># of Attendees</th>
<th>Room(s)</th>
<th>Debriefing Room: Yes/No</th>
<th>Equipment/Supplies Needed</th>
<th>Record Session: Yes/No</th>
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For Internal Use Only:
Admin sign off: ___________________________ Date: __/__/____
Director sign off: ___________________________ Date: __/__/____

Supplies Needed:
______________________________
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______________________________
______________________________