SUNY Downstate Medical Center

Center for Healthcare Simulation

Request Form

Today's Date: ____/____/____

Name: _____ Title: _____

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

Email Address: _____

College/Department: _____ Program: _____
(ie. undergraduate, graduate, RN, Residency, etc.)

Duration:
Begin Date: ____/____/_____ **End Date: ____/____/_____**
(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

Please list all dates in chronological order

Date	Activity Name	Faculty	Time	# of Attendees	Room(s)	Debriefing Room: Yes/No	Equipment/ Supplies Needed	Record Session: Yes/No

For Internal Use Only:
Admin sign off: _____ Date: ___/___/____
Director sign off: _____ Date: ___/___/____

Supplies Needed:

_____
_____
_____
_____