

**Phone Number** 

**Simulation Center** 

OFFICE USE ONLY: Date Received

COLLEGE OF OSTEOPATHIC MEDICINE

Date Fulfilled

Initials

#### Please complete all information to request a simulation-based experience. DATE

#### **CONTACT INFORMATION**

Name of Requester Email Organization Name if other than CHSU CHSU Department Name of Course or Event

CALIFORNIA

UNIVERSITY

### INSTRUCTIONS

If requesting a practice session with trainer, please skip to "**Setting**" and complete applicable sections of the form.

### SCHEDULING

Review the Simulation Calendar in SIMiQ for days and times available. After review, provide the desired day and time for the simulation-based experience. Availability is based on the Simulation Calendar. Day Time

### SCENARIO

First review the database in SIMiQ to find an appropriate scenario

Name of scenario chosen

### **Course Learning Objectives (CLOs)**

Please provide objectives that apply to this requested experience *All objectives should be S.M.A.R.T goals:* 

Specific Measurable Achievable Realistic Timely refer to Bloom's Taxonomy for measurable language

Please refer to Bloom's Taxonomy for measurable language

At the end of the session, the participant will be able to:

1. 2.

- z. 3.
- J. 4.
- 5.

6.

Does the scenario require revision to meet CLOs?  $\Box$ Yes  $\Box$ No

If yes, will the requester serve as the subject matter expert?  $\Box$  Yes

 $\Box$  No, who will be the SME?

# **CME/CE CREDIT**

The requested simulation-based experience is approved for continuing education credit. *NOTE: The requestor is responsible to complete all required forms.* 

□Yes □No

## PARTICIPANTS

Target Group

- $\Box$  1<sup>st</sup> year or Novice
- □ 2<sup>nd</sup> year or Advanced Beginner
- $\Box$  3<sup>rd</sup> year or Beginning Competent
- $\Box 4^{th}$  year or Emerging Competent
- $\Box$  Resident or Competent
- Other, (Please List)
- Interprofessional Roles Requested (check all that apply)

□ Student OT

□ Physician □ UAP

Student Physician Student UAP

- □ Resident Physician □ PT
- □ Pharmacist □ Student PT
- □Student Pharmacist □OT
- □RN
- □Student RN □Social Work
- □ RCP □ Student Social Work
- □Student RCP □Chaplain

Other, (Please List)

How many participants will be learners in the simulation-based experience?

Will there be any observers? Yes How many? No

### SETTING

Select the best possible locale for this simulation-based experience

Simulation Center In-Patient – Hospital			□Simulation Center Out-Patient – Clinic
Simulation Center AR Classroom			□Simulation Center Virtual Skills Classroom
□Office	□Stairwell	□Bathroom	□Parking Lot □Lobby
□Outside – Grass/Dirt/Quad □Classroom			
□Other			

#### TIMEFRAME

NOTE: Planning for all simulation events is to be done before each semester begins to ensure availability Requests after initial semester planning will be accomodated based on schedule and resources availability

When the simulation-based experience will be implemented:

□4 weeks□6 weeks□2 months□3 months□4 months□5 months□6 months□0ne year

Length of time the participant will be in the simulation-based experience. NOTE: The following time will be automatically added: Prebrief 5 minutes; Debrief 15 minutes

□ 14 minutes □ 15 minutes □ 23 minutes □ 30 minutes □ 60 minutes □ Longer

### FREQUENCY

This is the number of times the scenario will be run

□One-Time □Once per Module □Twice per Module

Once a semester during the academic year (twice a year)

Please List

## EQUIPMENT

Check as many as apply

 $\Box$  Advanced Computerized Mannequin

- □Task Trainer
- □ Standardized Patient
- □ Standardized Person
- □Other

# MANNEQUINS

### TRAINERS

**Eye Simulators** 

- Adult Male
  Adult Female
  Birthing Mom
  Bariatric/Obese
  5-year Old Pediatric
  Infant
- Ear Simulators
   Sam Cardionics
   Pat Cardionics
   Pelvic Examiners
   Prostate Examiners
- STANDARDIZED PARTICIPANTS
- ☐ Mother
  ☐ Father
  ☐ Daughter
  ☐ Wife
  ☐ Husband
  ☐ Child
  ☐ Adult Man
  ☐ Adult Woman

□Son □Relative □Grandfather □Friend

□ Adult Difficult Airway

Breast Examiners

**IV Practice Arms** 

Chester Chest

Pediatric Difficult Airway

□Grandmother □Stranger

### MOULAGE

□Yes □No Provide a brief description of what will add realism

# PROPS

□Yes □No Provide a brief list of items for realism