



**Center for Obstetrics and Gynecology Simulation**  
 Simulation Course: Training for the Unexpected  
 Spring 2012 Registration Form

Contact Person: \_\_\_\_\_ Hospital: \_\_\_\_\_  
 Title: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Address 1: \_\_\_\_\_  
 Address 2: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_

Course Participants\*:

Name/Dept: \_\_\_\_\_  MD  NP  CNM  RN  Other DOB (mm/dd) \_\_\_\_\_  
 Name/Dept: \_\_\_\_\_  MD  NP  CNM  RN  Other DOB (mm/dd) \_\_\_\_\_  
 Name/Dept: \_\_\_\_\_  MD  NP  CNM  RN  Other DOB (mm/dd) \_\_\_\_\_  
 Name/Dept: \_\_\_\_\_  MD  NP  CNM  RN  Other DOB (mm/dd) \_\_\_\_\_  
 Name/Dept: \_\_\_\_\_  MD  NP  CNM  RN  Other DOB (mm/dd) \_\_\_\_\_  
 Name/Dept: \_\_\_\_\_  MD  NP  CNM  RN  Other DOB (mm/dd) \_\_\_\_\_

Date of Birth (DOB) is required by the Accreditation Council for Continuing Medical Education (ACCME) for credit tracking purposes only.

**\* A care team is defined as a minimum of 1 Physician and 3 Nurses.  
 Ideally, a care team should consist of 2 Physicians and 4 Nurses.**

**Please call 585-273-1975 to confirm availability of course dates.**

Course dates: (Choose One)

- February 15, 2012                       March 13, 2012                       April 10, 2012  
 May 31, 2012                               June 19, 2012

Course Fee:	Nurse	\$150.00
	Advanced Practice Nurse	\$275.00
	Physician	\$650.00

Please return form via mail or fax to:  
 University of Rochester Medical Center  
 Center for Ob/Gyn Simulation  
 Attn: Deb Trommer  
 601 Elmwood Avenue, Box 668  
 Rochester, NY 14642  
 Fax: 585-276-2080

An invoice for payment will be sent to contact person after registration form is received. Please make check or money order payable to the *Center for Obstetrics and Gynecology Simulation* and send to the address above.  
 Payment must be submitted at least 2 weeks prior to your course date.

**How did you hear about us?**

\_\_\_\_\_ Direct Mailing      \_\_\_\_\_ Peri-FACTS®      \_\_\_\_\_ Colleague/Co-worker      \_\_\_\_\_ Internet      \_\_\_\_\_ E-mail



## Center for Obstetrics and Gynecology Simulation Survey

Please fill out the survey below and mail in with registration. The information provided will be helpful to us in making your experience as valuable as possible.

Name: \_\_\_\_\_

Hospital: \_\_\_\_\_

Number of deliveries per year: \_\_\_\_\_

Number of Staff within OBGYN department:

Physicians: \_\_\_\_\_

Nurse Practitioners: \_\_\_\_\_

Certified Nurse Midwives: \_\_\_\_\_

Nurses: \_\_\_\_\_

Does your institution currently have a simulator, or looking to purchase one?  Yes  No

If yes, what type of simulator: \_\_\_\_\_

Do any participating care team members have simulation experience?  Yes  No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are your goals upon completion of the course? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please include any other comments below that may be helpful when preparing your course: