



**Center for Obstetrics and Gynecology Simulation
Program Development Course
2011 Registration Form**

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

Participants:

Name: _____ Title: _____
Name: _____ Title: _____
Name: _____ Title: _____
Name: _____ Title: _____
Name: _____ Title: _____
Name: _____ Title: _____

Please contact Kaitlin Donals at (585) 273-1975 for course dates.

Course Fee: \$400.00 (up to 4 persons)

Please return form via mail or fax to:
University of Rochester Medical Center
Attn: Kaitlin Donals
Center for Obstetrics and Gynecology Simulation
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.



Center for Obstetrics and Gynecology Simulation Survey

The survey below is not mandatory for registration. However, any 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: