



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

Contact Person: _____ Hospital: _____

Title: _____ E-mail Address: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Course Participants*:

- _____ MD NP CNM RN Other DOB (mm/dd) _____
- _____ MD NP CNM RN Other DOB (mm/dd) _____
- _____ MD NP CNM RN Other DOB (mm/dd) _____
- _____ MD NP CNM RN Other DOB (mm/dd) _____
- _____ MD NP CNM RN Other DOB (mm/dd) _____
- _____ 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 for care teams: (Choose One)

- September 22, 2009 October 6, 2009 November 10, 2009 December 4, 2009
- November 16, 2009 December 15, 2009

Course date for individual registrants:

- October 14, 2009

Course Fee:	Nurse	\$125.00
	Nurse Practitioner or Certified Nurse Midwife	\$175.00
	Physician	\$450.00

15% reduction rate on care teams of 4 or more

Please return form via mail, e-mail, or fax to:
 University of Rochester Medical Center
 Attn: Kaitlin Donals
 601 Elmwood Avenue, Box 668
 Rochester, NY 14642
 E-mail: OB_Simulation@urmc.rochester.edu
 Fax: 585-276-2080

A confirmation 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 above address no later than 2 weeks after confirmation is received.



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: