Clinical Skills

Initial Activity Form

The information you provide in this form will better assist the Clinical Skills staff in preparing for your event.

Please note the following:

- This form must be returned to Brandon Freeman (bfreeman@ghs.org) at least **4 weeks prior** to your event date.
- Your event will then be **TENTATIVELY** placed on the Clinical Skills calendar upon receipt of this form.
- Your event is not **CONFIRMED** on the Clinical Skills calendar until all of the following materials are received no later than **3 weeks** prior to your event date: **SP scenarios/cases, door notes, and checklists**.

If you need assistance with this form or preparing materials for your event, please contact the following Clinical Skills staff for support:

Brandon Freeman – Clinical Skills Coordinator – 864/455-2282 – bfreeman@ghs.org

Sharon Youkey, RN – Standardized Patient Educator – 864/455-8728 – syoukey@ghs.org

The "Submit" button at the bottom of this form prepares an email to submit to Brandon Freeman.

*** Items in RED are required in order to submit the completed form.**

1. **Date of Request (Enter today's date)**

2. **Date of Activity**

3. **Lead Faculty/Facilitator Name and Credentials**

4. **Phone number**

5. **Email address**

6. **Please check all items you will be providing 3 weeks prior to your event (confirms your event on the Clinical Skills calendar):**

   ☐ SP scenarios/cases ☐ Door Notes ☐ Checklists

7. **Name of person providing these items?**

8. **Name of Activity**

9. **Why are you offering this course**

   If other, please explain:

10. **Target audience: (M1, RN, CRNA, Pharmacy)**

11. What equipment (stethoscope, BP cuff) and supplies (foley catheter trays, sterile gloves) do you need?

12. Target Schedule (Select one)

If other, please explain:

13. How many participants will attend each session?

14. How many instructors/facilitators will attend each session?

15. Objectives – What will the participant be able to demonstrate by the end of this course?

16. Outline your Activity Agenda

Example:
8:00 – 9:00 Lecture in Classroom
9:00 – 10:00 Small group discussion
10:00 – 12:00 SP scenario in groups of 4

17. Do you plan to evaluate each student's performance?

18. How many stations do you plan on having for this event? Please specify number of SP stations.

19. Rooms requested (Please select all that apply)

- ☐ Exam Room 1
- ☐ Exam Room 2
- ☐ Exam Room 3
- ☐ Exam Room 4
- ☐ Exam Room 5
- ☐ Exam Room 6
- ☐ Exam Room 7
- ☐ Exam Room 8
- ☐ Exam Room 9
- ☐ Exam Room 10
- ☐ Exam Room 11
- ☐ Exam Room 12
- ☐ Exam Room 13
- ☐ Exam Room 14
- ☐ SP Training Area
- ☐ Classroom 1
- ☐ Classroom 2

20. Will standardized patients be needed?

If yes, how many? Any specifications (i.e. age, gender)?

21. Do you want the Standardized Patients to provide feedback to the participants?

If yes, what type of feedback?

22. Does this event need to be recorded?

23. Is your course associated with a CBT in HealthStream?

24. Is your course approved for CME or CE credit?

25. Is there anything else you would like for us to know about this activity?