ECSR: Application for Sliding Scale Payment

I am requesting a reduction in the purchase price of the *Essentials in Cardiac Surgical Resuscitation* Educational Tool-Kit© based on the information below. I understand that this application is not a guarantee or final contract. If a reduced price is approved, I will receive email notification within 30 days of submitting this application and can decide if I wish to request an invoice at that time. My signature below indicates that all information included here is accurate to the best of my ability.

1. What is the name and location (city/state) of the requesting facility?

   _____

   _____

2. What is the total bed size of your hospital? _____
3. How many critical care beds do you have? _____
4. How many cardiac surgical patients do you care for each year? _____
5. Do you have administrative support to proceed with ECSR training? Yes___ No ____
6. Do you have the support of your surgeon(s) to proceed with training? Yes___ No ____
7. Which providers do you anticipate training (circle all):

   a) ICU RN b) Step-down RN c) Advanced practice providers d) Pharmacist

   e) Respiratory therapist f) Intensivist g) Medical trainees h) Other
8. How many ECSR instructors will conduct training during the first year? _____
9. How many ECSR providers do you expect to train during the first year? _____
10. What one-time fee would be feasible for your department to obtain this resource:

    a) $3000 b) $2500 c) $2000 d) $1500 e) $1000
11. Please feel free to attach any additional information about your facility that you feel would be helpful in making this determination.

Signature: _____ Date: _____

Title: _____

Return to: ECSR Director Jill Ley at jill@ecsr.info