

UNIVERSITY HOSPITAL VALUE ANALYSIS PROGRAM
VAP Coordinator & SUNY Upstate Medical University
Facilitator

Please print or type

Sub-Group Committee Information – Clinical Trial Information

Date: _____

Value Analysis Facilitator: _____

Evaluation Dates: From: _____ TO _____

Sub-Group Committee Members/Department:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Location for Evaluation:

Specify Areas

a) One Area: _____

b) Several Areas: _____

In-service by:

Specify Name

a) Vendor: _____

b) MM Clinical Educator: _____

c) Not Required YES N/A

Product for evaluation

Will be:

a) Supplied by vendor YES NO
Cost: _____

b) Purchased by Requestor YES NO
Cost: _____

c) Other _____

The evaluation results must be submitted upon completion of the trial to the Value Analysis Coordinator within two weeks of ending trial.

Facilitator Signature: _____ Date: _____