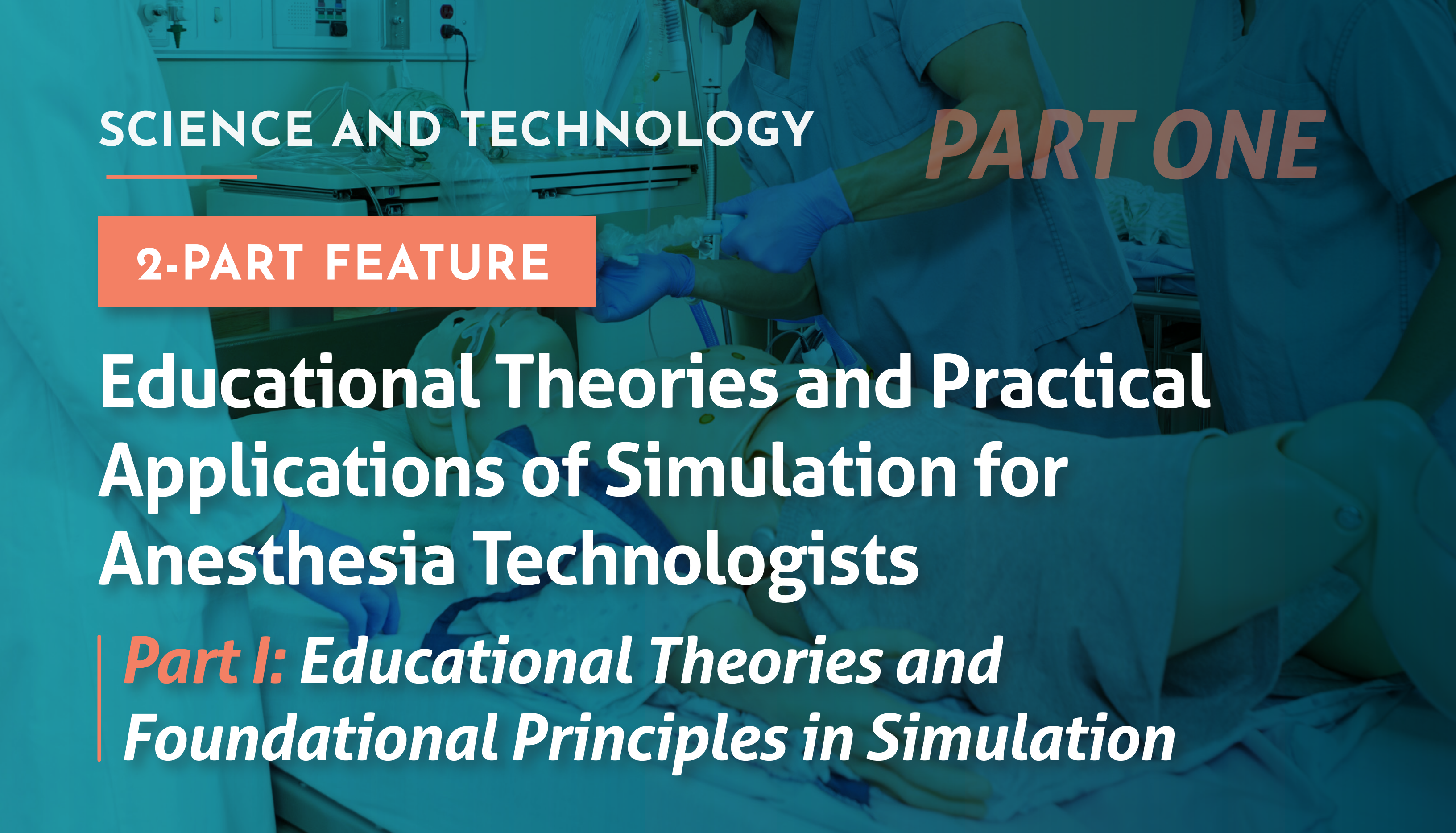

SCIENCE AND TECHNOLOGY

PART ONE

2-PART FEATURE

Educational Theories and Practical Applications of Simulation for Anesthesia Technologists

Part I: Educational Theories and Foundational Principles in Simulation

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ABSTRACT

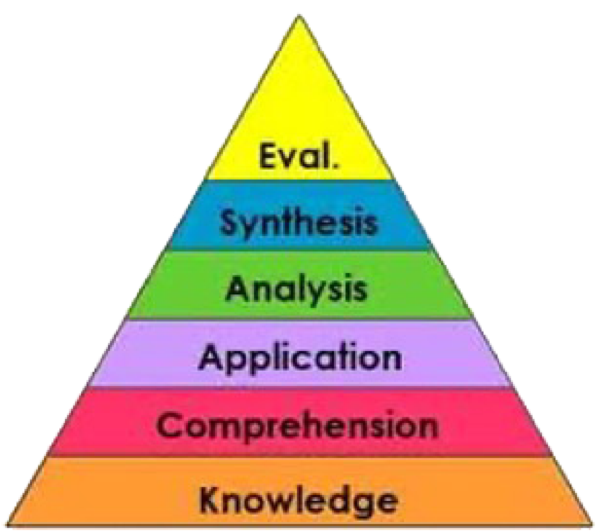
Simulation is a high-impact modality for bridging theory and clinical practice in anesthesia technology. Part One of this article synthesizes core learning frameworks, Kolb's experiential learning cycle, constructivism (Vygotsky), adult learning theory (Knowles), and Bandura's social learning theory, to explain how learners acquire, integrate, and apply knowledge in simulation. These theories ground the three facilitation phases (pre-brief, active facilitation, debrief) and foundational principles such as psychological safety, authenticity, and alignment with learning objectives. Part Two translates theory to practice across two complementary delivery models: (1) in situ simulation, conducted in the operating room with native equipment and teams to surface latent safety threats and strengthen real-world workflows; and (2) academic simulation centers, which support deliberate practice, controlled complexity, and longitudinal curriculum design. Practical applications include equipment management and troubleshooting, crisis resource management (e.g., malignant hyperthermia), advocacy and interprofessional communication, and rapid turnover workflow integration. Together, academic and in situ approaches form a continuum that scaffolds psychomotor skills and non-technical competencies, communication, situational awareness, and teamwork, ultimately enhancing patient safety and professional identity. The article concludes that simulation, when intentionally aligned to theory and standards, should be treated as essential infrastructure for anesthesia technology education and ongoing clinical competence.

INTRODUCTION

Simulation in healthcare education has emerged as one of the most effective modalities for bridging the gap between theoretical knowledge and clinical practice (Aebersold, 2018; Romancenco et al., 2024). For anesthesia technologists, simulation offers a controlled, structured environment where technical skills, critical thinking, and interprofessional collaboration can be developed and refined. The benefits of simulation for anesthesia technologists extend beyond the academic setting, offering ongoing applicability in current practice as a means of ensuring competence and enhancing skills for continuous quality improvement. However, to maximize its effectiveness, simulation must be grounded in educational theory and organized through structured facilitation phases (Aebersold, 2018; Romancenco et al., 2024). The purpose of part one is to explore the theoretical foundations of simulation, which inform the facilitation of simulation encompassing the pre-brief, active facilitation, and debrief.

EDUCATIONAL THEORIES UNDERPINNING SIMULATION

Simulation is not simply a teaching tool but an educational strategy grounded in established learning theories (Aebersold, 2018; Romancenco et al., 2024). For anesthesia technologists looking to implement simulation in an academic program or workplace, understanding the theories that underpin healthcare simulation is essential for effectively designing, facilitating, and evaluating simulations to achieve desired outcomes for students or employees. Although there are countless theories and practices related to simulation education, so extensive that entire curricula, multiple textbooks, and ongoing research are devoted to them, this article will focus on a select group of well-established theories that span the full spectrum of simulation delivery and education. For this reason, this article will only address four core theories: Kolb's (1984) Experiential Learning Theory, Vygotsky's (1978) additions to Constructivist theory, Malcolm Knowles (1970) Adult Learning Theory, and Bandura's (1977) Social Learning Theory.



Bloom's Taxonomy Pyramid

KOLB'S EXPERIENTIAL LEARNING THEORY

Kolb's Experiential Learning Theory (ELT) posits that learning is a cyclical process involving four stages: concrete experience, reflective observation, abstract conceptualization, and active experimentation (Aebersold, 2018; Kolb, 1984; Romancenco et al., 2024). These four pillars in the cycle cumulatively form the necessary learning environment for students to shape their theoretical knowledge into comprehensible and competent practices (Kolb, 1984).

Kolb's Learning Cycle

The first stage of Kolb's learning cycle is the Concrete Experience (Aebersold, 2018; Kolb, 1984; Romancenco et al., 2024). In this stage, learners are placed in a situation where theory intersects with psychomotor skillsets. Within simulation, this occurs during the scenario-based event where students' cognitive, psychomotor, and affective abilities are intentionally challenged. In this "doing" space, learners are immersed in the environment, actively engaging in the scenario and moving from abstract theoretical content to a lived experience emphasized by hands-on experiential training (Aebersold, 2018; Kolb, 1984; Romancenco et al., 2024). For the instructor or simulation facilitator, it is important not to treat the concrete experience as an assessment or a demand for perfection. Instead, it should be a safe space where participants can apply what they know in a controlled environment, one where no real patient can be harmed (DiGregorio et al., 2025; Turner et al., 2023). This approach allows both learners and observers to naturally recognize moments of cognitive overload and uncover practice deficits (Madsgaard & Svellingen, 2025). The expectation is that subsequent stages of the cycle will build upon these insights, creating new learning that can later be applied in real-world practice to positively impact patients and communities.

In the second stage of the learning cycle, participants are tasked with reflecting on the concrete event that has just occurred (Kolb, 1984). This stage is often referred to as the debrief and is widely considered the most critical phase of simulation, as it is through reflection that learners make meaningful connections to practice, evaluate performance, and identify how they can improve and apply new learning in the future (Abulebda et al., 2022). At this stage, the facilitator's focus shifts from what learners did to how they are thinking about their actions. The primary goal is to establish a psychologically safe environment where participants and active observers feel comfortable sharing their thoughts, feelings, and emotions about the event (Madsgaard & Svellingen, 2025). In this judgment-free space, authentic learning occurs because the environment fosters openness, encourages recognition of growth opportunities, and highlights individual and team strengths. It is essential that psychological safety is upheld in this stage; without it, the remaining phases of the cycle are undermined, and the process of knowledge development necessary for future clinical practice is disrupted (Madsgaard & Svellingen, 2025; Turner et al., 2023). In simulation, anesthesia technologists gain concrete experiences by engaging in simulated cases, reflect during and after scenarios, conceptualize lessons learned, and apply those lessons in future clinical practice.

In the third stage of Kolb's learning cycle, learners begin the process of making meaning from what they have experienced and reflected upon (Aebersold, 2018). This stage is not about the immediate doing or the emotional processing of reflection, but rather about constructing new frameworks of understanding that can inform future action (Fegran et al., 2022, Madsgaard & Svellingen, 2025; Turner et al., 2023). Learners abstract from the concrete event, synthesizing their own insights with feedback from facilitators and peers to create broader principles or mental models that guide performance.

Here, the focus shifts toward evaluating current abilities against standards of competence and identifying how new knowledge can be organized into strategies for improvement (Fegran et al., 2022). Much like Bloom's hierarchy, learners advance from simply knowing and understanding toward application, where knowledge is translated into practical use. Within clinical practice, this stage aligns with Miller's pyramid

Miller's Pyramid of Clinical Competence

of clinical competence, where learners move from "knows how" toward demonstrates (Miller, 1990; Miller et al., 2010). In this way, abstract conceptualization becomes the bridge between the raw experience of simulation and the structured, theory-informed practice required in the real world (Stocker et al., 2014).

The final stage of Kolb's experiential learning cycle is active experimentation. In this phase, learners take the insights, mental models, and skills developed through reflection and conceptualization and apply them to future practice (Aebersold, 2018; Kolb, 1984; Romancenco et al., 2024). This may occur in a subsequent simulation scenario, where they test new strategies in a psychologically safe environment, or in direct patient care, where theory and practice converge in real-world settings.

What distinguishes this stage is the forward movement, it represents the learner's opportunity to implement change, refine behaviors, and validate their growth (Aebersold, 2018; Kolb, 1984; Romancenco et al., 2024). Importantly, this stage underscores that experiential learning is not a one-time event but an ongoing cycle. Each attempt at applying new learning generates another opportunity for experience, reflection, and refinement, ensuring continuous development of competence and confidence.

Kolb's experiential learning cycle offers a clear framework for understanding how learners move from experience to practice. Beginning with the concrete experience, learners are immersed in simulation events that demand engagement of their cognitive, psychomotor, and affective domains (Aebersold, 2018; Kolb, 1984; Romancenco et al., 2024). Through reflective observation, they are guided to critically examine their actions, decisions, and emotions in a psychologically safe environment. With abstract conceptualization, these reflections are transformed into new insights, mental models, and systems of practice, linking experience with broader theoretical and clinical frameworks. Finally, in active experimentation, learners apply these insights to subsequent simulations or real patient care, completing the cycle and beginning it anew.

When viewed as a whole, Kolb's model reflects the essence of simulation-based education: a safe, iterative process where learners build competence by cycling between doing, reflecting, and applying. Yet Kolb's framework also highlights an important truth, learning does not occur in isolation (Fegran et al., 2022, Madsgaard & Svellingen, 2025; Turner et al., 2023). Knowledge is constructed not only through individual processing of experience but also through social interaction, collaboration, and the co-construction of meaning. This understanding provides a natural transition to constructivist theory, which emphasizes that learners actively build their understanding through engagement with others and with their environment.

CONSTRUCTIVISM AND THE ZONE OF PROXIMAL DEVELOPMENT

Constructivism, as advanced by theorists such as Vygotsky, emphasizes that learning is not a passive process (Eller et al., 2024). Rather, knowledge and meaning are actively constructed through experience, reflection, and social interaction. In simulation-based education, constructivism aligns closely with both the concrete experience and the collaborative elements of the learning cycle (Eller et al., 2024; Rudolph et al., 2014). Central to this application is Vygotsky's concept of the Zone of Proximal Development (ZPD), which serves as a guide for facilitators when designing skill-appropriate simulations. The ZPD represents the balance between tasks that are too simple, where learners become disengaged due to a lack of cognitive challenge, breaking the suspension of disbelief, and tasks that are overly complex, which risk overwhelming the learner, undermining psychological safety, and ultimately leading to a failed simulation experience (Eller et al., 2024; Rudolph et al., 2014). Within the ZPD, learners possess the foundational skills to succeed but require appropriate scaffolding and guided support. Here, facilitators design and implement scenarios that challenge learners just enough to promote engagement and growth, while still allowing them to achieve success with minimal assistance (Eller et al., 2024; Rudolph et al., 2014).

Within constructivist theory lie additional foundational concepts: scaffolding and authenticity. Scaffolding, closely tied to the ZPD, requires that simulations be designed with intentionality (Madsgaard & Svellingen, 2025). This begins with structured prebriefing, where ground rules are established, psychological safety is prioritized, and learners are oriented to the environment to minimize distractions or barriers to learning (Eller et al., 2024; Madsgaard & Svellingen, 2025). Without this intentional setup, learners placed into a scenario without context, clear expectations, or knowledge of where resources are located are more likely to experience frustration, resulting in simulations that fail to meet objectives and waste both facilitator and learner time. Scaffolding also extends into the debrief, which must be purposefully designed to promote the development of new mental models and the integration of knowledge gained through experience and reflection (Eller et al., 2024; Madsgaard & Svellingen, 2025). Without grounding debriefing in validated theory and tools, long-term objectives and meaningful learning outcomes cannot be achieved.

Authenticity serves as the second essential constructivist principle. At its core, authenticity asks whether the environment, scenario, and physiological responses of the simulation align with reality (Elendu et al., 2024). If the simulation lacks a credible connection to clinical practice, scaffolding collapses, the ZPD becomes illusory, and opportunities for social interaction, meaning-making, and learning are diminished (Eller et al., 2024; Madsgaard & Svellingen, 2025). Importantly, authenticity does not require multimillion-dollar simulators or highly complex setups. Rather, effective authenticity is achieved when the design, flow, and expectations of the simulation are grounded in validated literature and reflect real-world clinical situations (Elendu et al., 2024). For example, a thoughtfully placed verbal cue during a code-blue event using only a CPR manikin may be far more impactful

Photo credit: Stanford EdTech

than an elaborate scenario run poorly with expensive equipment and inadequate facilitation. Simulation allows anesthesia technologists to build understanding by engaging with realistic clinical scenarios, making decisions, and learning from consequences within a safe environment. While constructivism explains how knowledge is socially constructed through experience and reflection, it does not fully address the unique needs of adult learners. Simulation in the health professions primarily serves adults, making andragogy, or adult learning theory, a critical lens. By linking constructivist principles with adult learning theory, facilitators can design simulations that not only mirror reality but also resonate with learners' prior experiences, professional goals, and intrinsic motivation.

KNOWLES' ADULT LEARNING THEORY – ANDRAGOGY

Adult learning theory, often referred to as andragogy, is closely associated with the work of Malcolm Knowles, who proposed that adults learn differently than children (Knowles, 1970). Pedagogy, the traditional model of education for children, frames learning as a dependent process in which instructors direct students in a structured, controlled manner (Knapke et al., 2024; Knowles, 1970). In contrast, andragogy emphasizes that adult learners are self-directed, bringing their own lived experiences, motivations, and a strong requirement for relevance in the learning process (Knapke et al., 2024; Knowles, 1970).

Photo credit: Gene Hobbs

Healthcare simulation aligns naturally with these andragogical principles. By its experiential nature and grounding in authentic, constructivist practices, simulation clearly establishes for the learner not only what needs to be known but also why it matters, thereby validating both the educational process and its clinical application (Elendu et al., 2024). Simulation further supports the adult learner's self-concept by providing a safe environment in which they can see themselves as autonomous and responsible for their own decisions, an opportunity not always available in clinical settings, where students may be limited to observation rather than active practice (Elendu et al., 2024).

Importantly, simulation also respects and utilizes the prior experiences that adult learners bring with them. Rather than penalizing gaps in knowledge or ingrained habits, simulation provides opportunities for learners to express, refine, and improve their skills in a psychologically safe space (Turner et al., 2023). Whether for students in academic programs or practicing professionals engaged in ongoing competency training, simulation situates learning within immediately relevant clinical contexts, allowing anesthesia technologists and other healthcare providers to recognize the direct applicability of their learning to patient care.

While andragogy highlights the importance of self-direction, relevance, and lived experience in adult education, it does not fully account for the powerful influence of observation, modeling, and social interaction in shaping learning. This is where Albert Bandura's social learning theory extends the conversation (McLeod, 2025). By emphasizing that much of what we learn comes not only from doing but also from watching others and interpreting their actions, Bandura provides an essential lens for understanding how simulation fosters growth through teamwork, role modeling, and guided practice (McLeod, 2025).

BANDURA'S SOCIAL LEARNING THEORY

Emerging from the limitations of behaviorist models, Bandura's Social Learning Theory emphasizes that learning occurs not only through direct experience but also through observation, imitation, and modeling (Bandura, 1977). Bandura argued that people do not simply learn from doing, but through active observation, a concept highly relevant to simulation-based education. The theory rests on four key pillars: Attention, Retention, Reproduction, and Motivation (Bandura, 1977; McLeod, 2025).

Attention refers to the learner's ability to focus on the behavior or action being modeled, often described as vicarious learning. In simulation, this highlights the importance of intentionally designing experiences for both active participants and observers (Bandura, 1977). Facilitators must create an environment where observers are given clear expectations about what to watch for and how their insights will inform the debrief. In this way, observation becomes just as purposeful and impactful as direct participation (Eller et al., 2024).

This intentional structure enhances Retention, as learners are more likely to encode and remember what they have observed when they understand its relevance (Eller et al., 2024). Strong retention then provides the basis for Reproduction, where learners translate what they have seen into practice, either in the simulation environment or later in clinical care (Elendu, 2024). Together, these processes cultivate Motivation, as learners are more inclined to adopt and internalize behaviors when they see their peers model success and receive reinforcement through feedback.

Ultimately, social learning theory strengthens the principles of andragogy by recognizing that adults learn not only through self-directed practice but also through peer-to-peer collaboration, teamwork, and observation. In simulation, whether a learner is an active participant or an observer, the design and facilitation of the experience ensure that all learners are positioned to reinforce and achieve the intended outcomes.

ABOUT THE AUTHOR

Bryan Fulton currently serves as the Director of Health Professions Labs and Simulations at Oklahoma City Community College, where he also holds the role of Program Director for Anesthesia Technology. In these capacities, he oversees the OCCC Simulation Center, a multidisciplinary facility supporting seven academic programs: Anesthesia Technology, Emergency Medical Sciences, Nursing, Occupational Therapy Assistant, Physical Therapy Assistant, Speech-Language Therapy Assistant, and Respiratory Therapy.

Dr. Fulton earned his Doctorate in Higher Education Leadership from Baker University, a Master's Degree in Community College Leadership from the University of Arkansas, and a Bachelor's Degree from Belhaven University. His research explores the dynamics of faculty-student interactions in health professions education and how these relationships influence persistence, retention, and program completion. Additionally, his scholarship examines the role of simulation in improving academic outcomes, with a focus on high-fidelity simulation and standardized patient–based simulation.

As Director, Dr. Fulton has led the implementation of the Anesthesia Technology simulation curriculum, providing students with 288 hours of structured simulation experiences that meet professional practice standards for substituting portions of clinical fieldwork. His expertise has made him a valued resource for nursing programs across Oklahoma seeking to integrate simulation as a replacement for clinical hours.

He is deeply passionate about advancing the role of simulation in healthcare education, particularly in fostering psychological safety, reducing medical errors, and strengthening the preparation of future health professionals to better serve their communities.

References

Abulebda, K., Auerbach, M., & Limaiem, F. (2022, September 26). *Debriefing techniques utilized in medical simulation.* StatPearls - NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK546660/

Aebersold, M. (2018). Simulation-Based learning: no longer a novelty in undergraduate education. *OJIN the Online Journal of Issues in Nursing, 23*(2). https://doi.org/10.3912/ojin.vol23no02ppt39

Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.

DiGregorio, H., Todd, A., Blackwell, B., Brennan, B. A., Repsha, C., Shelton, C. M., Vaughn, J., Wands, L., Wruble, E., & Yeager, C. (2025). Healthcare Simulation Standards of Best PracticeR Facilitation. *Clinical Simulation in Nursing, 105*, 101776. https://doi.org/10.1016/j.ecns.2025.101776

Elendu, C., Amaechi, D. C., Okatta, A. U., Amaechi, E. C., Elendu, T. C., Ezeh, C. P., & Elendu, I. D. (2024). The impact of simulation-based training in medical education: A review. *Medicine*, 103(27), e38813. https://doi.org/10.1097/MD.0000000000038813

Eller, S., Vlasses, F., Horsley, T. L., & Connor, J. (2024). Simulation psychological safety ecosystem: using constructivist grounded theory to explore nurses' experiences with prelicensure simulation. *International Journal of Healthcare Simulation*. https://doi.org/10.54531/pdfa3882

Fegran, L., Ham-Baloyi, W. T., Fossum, M., Hovland, O. J., Naidoo, J. R., Van Rooyen, D., Sejersted, E., & Robstad, N. (2022). Simulation debriefing as part of simulation for clinical teaching and learning in nursing education: A scoping review. *Nursing Open*, 10(3), 1217–1233. https://doi.org/10.1002/nop2.1426

Knapke, J. M., Hildreth, L., Molano, J. R., Schuckman, S. M., Blackard, J. T., Johnstone, M., Kopras, E. J., Lamkin, M. K., Lee, R. C., Kues, J. R., & Mendell, A. (2024). Andragogy in Practice: Applying a Theoretical Framework to Team Science Training in Biomedical Research. British journal of biomedical science, 81, 12651. https://doi.org/10.3389/bjbs.2024.12651

Knowles, M. S. (1970). The Modern practice of adult education : andragogy versus pedagogy /. In *Association Press eBooks*. https://ci.nii.ac.jp/ncid/BA14426230

Kolb, D. A. (1984). *Experiential learning: Experience as the Source of Learning and Development.* Englewood Cliffs, N.J. : Prentice-Hall.

Jeffries, P. R. (2020). *Simulation in nursing education.* Nln.

Levine, A. I., DeMaria, S., Jr, Schwartz, A. D., & Sim, A. J. (2014). *The Comprehensive Textbook of Healthcare Simulation.* Springer.

Madsgaard, A., & Svellingen, A. (2025). The benefits and boundaries of psychological safety in simulation-based education: an integrative review. BMC nursing, 24(1), 922. https://doi.org/10.1186/s12912-025-03575-y

Maxworthy, J. C., Palaganas, J. C., & Epps, C. A. (2022). *Defining excellence in simulation programs.* LWW.

McLeod, S. (2025, March 18). *Albert Bandura's Social Learning Theory.* https://www.simplypsychology.org/bandura.html

Miller, C., Nentl, N., & Zietlow, R. (2010). About simulations and Bloom's learning taxonomy. *Developments in Business Simulations and Experiential Learning, 37*, 161-166. https://absel-ojs-ttu.tdl.org/absel/article/view/305/271

Miller, G. E. (1990). The assessment of clinical skills/competence/performance. *Academic Medicine,* 65(9 Suppl), S63-S67. https://doi.org/10.1097/00001888-199009000-00045

Romancenco, A., Saratila, I., Ababii, I., Rojnoveanu, G., Dandara, O., & Spinei, L. (2024). Bridging theory and practice: enhancing medical education through simulation-based training methods. *Moldovan Journal of Health Sciences*, 11(2), 68–73. https://doi.org/10.52645/mjhs.2024.2.09

Rudolph, J. W., Raemer, D. B., & Simon, R. (2014). Establishing a safe container for learning in simulation. *Simulation in Healthcare the Journal of the Society for Simulation in Healthcare,* 9(6), 339–349. https://doi.org/10.1097/sih.0000000000000047

Stocker, M., Burmester, M., & Allen, M. (2014). Optimisation of simulated team training through the application of learning theories: a debate for a conceptual framework. *BMC medical education*, 14, 69. https://doi.org/10.1186/1472-6920-14-69

Turner, S., Harder, N., Martin, D., & Gillman, L. (2023). Psychological safety in simulation: Perspectives of nursing students and faculty. *Nurse Education Today,* 122, 105712. https://doi.org/10.1016/j.nedt.2023.105712

Vygotsky, L. S. (1978). *Mind in Society: Development of Higher Psychological Processes* (M. Cole, V. Jolm-Steiner, S. Scribner, & E. Souberman, Eds.). Harvard University Press. https://doi.org/10.2307/j.ctvjf9vz4

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Continuing Education Quiz

To test your knowledge on this issue's article, provide correct answers to the following questions on the form below. Follow the instructions carefully.

1. Which of the following is NOT one of Kolb's four stages of experiential learning?
A) Concrete Experience
B) Reflective Observation
C) Abstract Conceptualization
D) Cognitive Retention

2. In Kolb's model, which stage is most closely associated with debriefing in simulation?
A) Concrete Experience
B) Reflective Observation
C) Abstract Conceptualization
D) Active Experimentation

3. Vygotsky's Zone of Proximal Development (ZPD) emphasizes:
A) Learning through repetition alone
B) Tasks too easy to require guidance
C) Learning supported through scaffolding and guided challenge
D) Independent performance without external input

4. Which constructivist principle ensures that simulations mirror clinical reality?
A) Scaffolding
B) Authenticity
C) Reproduction
D) Motivation

5. According to Knowles' Adult Learning Theory, pedagogy differs from andragogy in that:
A) Adults are dependent learners
B) Children require relevance and autonomy
C) Adults are self-directed and motivated by relevance
D) Children build knowledge through social modeling

6. Which of the following is a key tenet of adult learning theory as applied to simulation?
A) Learners must memorize before practicing
B) Learners thrive when given autonomy and relevance
C) Learning is best when unrelated to prior experience
D) Learning occurs in isolation, not in teams

7. Bandura's Social Learning Theory highlights which four pillars?
A) Motivation, Experience, Reflection, Retention
B) Attention, Retention, Reproduction, Motivation
C) Observation, Experimentation, Repetition, Feedback
D) Experience, Retention, Scaffolding, Autonomy

8. In simulation, observers benefit most when:
A) They watch passively without expectations
B) They are given structured goals for observation
C) They participate without any reflection
D) They repeat tasks immediately without feedback

9. The principle of psychological safety in simulation ensures:
A) Learners avoid mistakes at all costs
B) Mistakes lead to punitive consequences
C) Learners feel safe to reflect and take risks
D) Debriefing is optional after scenarios

10. Which statement best summarizes the relationship between theories in Part One?
A) They compete with one another and must be chosen exclusively
B) They provide complementary perspectives that scaffold simulation learning
C) They are only relevant in academic research, not practice
D) They apply only to pediatric education, not adult learners

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1.	A	B	C	D	6.	A	B	C	D
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3.	A	B	C	D	8.	A	B	C	D
4.	A	B	C	D	9.	A	B	C	D
5.	A	B	C	D	10.	A	B	C	D

Quiz 1

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