Tilman J. Fertitta Family College of Medicine
UNIVERSITY OF HOUSTON

Presenter Pre-Activity Questionnaire

Presenter Information

- **Full Name**: _____
- **Credentials**: _____
- **Institutional Affiliation**: _____
- **Email Address**: _____
- **Phone Number**: _____

Presentation Details

- **Title of Presentation**: _____
- **Date of Presentation**: _____
- **Duration of Presentation**: _____

Educational Content

1. **Learning Objectives**:
   Please list 3–5 specific, measurable learning objectives for your presentation.
   - Objective 1: _____
   - Objective 2: _____
   - Objective 3: _____
   - Objective 4: _____
   - Objective 5: _____
2. **Content Relevance**:
   Briefly describe how your presentation addresses identified educational gaps or needs within the target audience.
   _____
3. **Evidence-Based Practice**:
   Will your presentation include current, evidence-based information?

   ☐Yes

   ☐No
   If yes, please provide references or sources:
   _____

Conflict of Interest Disclosure

In accordance with ACCME standards, all presenters must disclose all financial relationships with ineligible companies. Please complete the **Financial Disclosure Form** and submit electronically through CME Tracker. A link to complete the disclosure form will be provided to you from the

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Presentation Materials

1. **Slide Submission**:
   Please submit your presentation slides to the Office of Continuing Medical Education no later than one (1) week prior to the scheduled presentation date.
2. **Handouts or Supplementary Materials**:
   Will you be providing any handouts or supplementary materials?

   ☐Yes

   ☐No
   If yes, please submit these materials along with your slides.

Audio/Visual Requirements

Please specify any audio/visual equipment or technical support you will require for your presentation:

_____

Consent for Recording

Do you consent to having your presentation recorded for educational purposes?

☐Yes

☐No

Acknowledgment

By signing below, I acknowledge that the information provided is accurate and complete. I agree to comply with the Office of Continuing Medical Education guidelines and deadlines.

Signature: _____

Date: _____