THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

UT College of Medicine
Office of Continuing Medical Education (CME)
920 Madison Avenue, 5th Floor, Suite 512
Memphis, TN 38163 • 901-448-5128

CME Activity Closeout Form

Activity Title:	**Activity Date(s):**
Activity Location:	
Activity Medical Director:	
Activity Coordinator:	

Total Hours CME Provided				
Hours of CME per Meeting or Course	X	**Number of Times Offered** (some CME activities meet more than once)	=	**Total Hours of CME**
	X		=	0
Distribution of Certificates: ☐ Mail or ☐ Email				

***Participation Summary:** (Please include all attendees, whether they receive AMA PRA Category 1™ credit or not.)	
Physicians (MD / DO)	
Non-Physicians (PhD / PA / NP / FNP / RN / LPN / Other)	
Residents / Fellows	
Students	
Total Participation	0

Attachments:

☐ **Participation Report** (Excel spreadsheet with First Name, Last Name, Degree, Number of hours CME, Email Address, Mailing Address)

☐ **Evaluation Summary**

☐ **Letter of Agreement** (if commercial support was received)

*For live activities (meeting, conference, symposium, DVP lecture), this is simply the number of persons who participated. However, for regularly scheduled series (RSS), such as grand rounds, tumor board, case conference, etc. this is the sum of the attendance totals for all sessions. For example, if the same ten (10) physicians attended each of the twelve (12) meeting dates of your RSS, you should enter 10 x 12 = 120 physicians in that category.

ATTESTATIONS: Please read the following attestations.
By signing you agree to abide by the policies and regulations addressed in this form.

- I attest that the Participation Report provided is accurate and commensurate to the best of my knowledge.
- I attest that all education provided at this CME activity was a) the same speakers & topics approved by the Office of CME, b) within the scope of the Learning Objectives on the CME Credit Application for this activity, c) evidence-based, d) free from promotion, and e) not biased by commercial interests.
- I attest that all individuals in a position to control the planning, content, implementation, & evaluation of this activity completed a disclosure form prior to the activity.
- I attest that the learning objectives, the AMA credit and Accreditation statement, any relevant financial relationships (or lack thereof) for all speakers, and any commercial support received for this activity (if applicable) were disclosed to the learners at this activity.

SIGNATURE: Activity Medical Director or Coordinator (typed or signed):	**DATE:**

Office of CME Use Only

Certificates - Created by: _____ Delivery Method: ☐ Mail or ☐ Email Date Issued: ____/____/____

Issued via: ☐ Individually, sent to each Physician or ☐ All certificates to: _____

CME Closeout Approval - _____ Documentation Completion Date: ____/____/____
Victor Carrozza, CME Director

PARS Activity ID: _____

Rev. 1/1/26