



**PRESENTATION REQUEST**

Date of Request \_\_\_\_\_

Name of Organization \_\_\_\_\_

Mailing Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Name & Title of Contact Person \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Requested Date & Time for Presentation \_\_\_\_\_

2<sup>nd</sup> Choice \_\_\_\_\_

Topic for Presentation \_\_\_\_\_

Audience (e.g. medical staff, residents, specialty, MEC's) \_\_\_\_\_

Number of attendees expected \_\_\_\_\_

Location of Presentation (e.g. address, room number, directions) \_\_\_\_\_

Honorarium offered (please specify amount) \_\_\_\_\_

LCD capability? Yes\_\_\_ No\_\_\_ Laptop? Yes\_\_\_ No\_\_\_

CPHP will provide learning objectives, brochures and other handouts.

**Please complete this form and return via mail or fax to:  
Colorado Physician Health Program  
Attention: Presentation Request  
899 Logan St. Suite 410  
Denver, CO 80203**

**Phone: 303-860-0122, Fax: 303-860-7426**