SUBMIT YOUR ABSTRACT!

14th Annual Johns Hopkins Critical Care Rehabilitation Conference

Nov. 6-7, 2025

In-Person Conference: Johns Hopkins Hospital, Baltimore, Maryland

Abstract Submission Deadline: June 30, 2025

More info at: icurehabnetwork.org

Abstract Options

- Abstract topics for Oral or Poster presentation on Nov. 6 or 7, 2025:
  - Any clinical quality improvement project, scientific research, or other non-commercial project relevant to the objectives of the conference
  - *Notes regarding oral presentations:
    - If accepted, PowerPoint slides due by October 17, 2025
    - There are a limited number of oral presentations; if not selected, a poster presentation may be offered
  - **Notes regarding poster presentations:
    - Poster must be printed on paper or cloth (electronic posters are not permitted)
    - Maximum poster dimensions are 40 x 80 inches (H x W)

Eligibility

- Abstracts are eligible even if previously presented at another conference
- **The oral or poster presenter must be a paid registrant**
  - Registration information is available at: ICURehabNetwork.org

JOHNS HOPKINS MEDICINE

Critical Care Physical Medicine & Rehabilitation Program

CALL for ABSTRACTS for POSTERS & ORAL PRESENTATIONS

at

14th Annual Johns Hopkins Critical Care Rehabilitation Conference

November 6 - 7, 2025

IN-PERSON AT JOHNS HOPKINS HOSPITAL, BALTIMORE, MD

ABSTRACT SUBMISSION DEADLINE: June 30, 2025

Abstracts will be accepted for poster or oral presentation as per the Conference abstract review committee's decision. Oral presentations will be a maximum of 10 minutes. **PowerPoint slides for accepted oral presentations must be submitted by October 17, 2025.**

CONFERENCE REGISTRATION REQUIRED: If an abstract is accepted for a poster or oral presentation, the presenter must be a paid registrant for the 14th Annual Johns Hopkins Critical Care Rehabilitation Conference. **Abstract submissions are eligible for submission even if presented at another conference previously.**

SUBMISSION: All abstracts must be submitted, using the guidelines outlined below, by **June 30, 2025.** Please save the completed form and email with subject "Abstract" to icurehab@jhmi.edu. The Program Committee will review submitted abstracts and make the final decision regarding acceptance and presentation format (i.e. poster or oral presentation) well in advance of the Conference. Final decisions will be provided via e-mail.

All abstract submissions should include a completed disclosure form (pages 4-6)
Abstracts are intended to represent clinical quality improvement projects, scientific research, or other non-commercial projects related to clinical practice or administration. Advertisements are not acceptable. Abstracts should not exceed 300 words and should be single-spaced. The use of product names or brand names in the title may lead to abstract disqualification. Abstracts require presenter/author information including credentials and complete contact information. Please organize the abstract section using the following headings:

- OBJECTIVE(S): Purpose of project/study
- METHODS: Summary of the project/study design or protocol
- RESULTS: Results of the project/study with appropriate statistical inferences
- CONCLUSIONS: Clinical importance and potential significance findings

- ◉ I wish to be considered for an oral presentation only
- ◯ I wish to be considered for poster presentation only
- ◯ I wish to be considered for either oral or poster presentation

1- I give permission to provide a copy of my poster to be publicly shared via the Conference website.

◉ **YES**
◯ **NO**

2- Full title of your proposal (using upper and lower case)

3- **Author(s)**: *(i.e. Jeff R. Nickoles, MD; Lauren K. Black, PT; Keshia A. Jones, B.Sc.)*

☐ I confirm that the following abstract has been approved by all authors listed above

4- Please enter an abstract of your proposal (maximum 300 words).

5- Primary author/presenter for abstract:

*** Indicates a mandatory field**

***First Name**

***Last Name**

Twitter Handle

***Professional Title**

***Degrees**

***Primary Affiliation**

***Email Address**

***Phone #**

***Alternative Email**

***Alternative Phone #**

***Mailing Address**

***City**

***State/Province**

***Country**

***Postal Code**

☐ * I confirm that I have completed the disclosure form (pages 4-6) to the best of my knowledge, and that I will inform the conference organizers if the disclosure needs to be updated.

Please complete all boxes marked with an asterisk in the following pages. These are mandatory fields. If not completed, your abstract will not be reviewed. You must also sign and date the form in the appropriate location.

JOHNS HOPKINS MEDICINE

Faculty My CME

Disclosure of Relevant Financial Relationships

*Name

Information You Need to Know to Disclose Your Financial Relationships with Companies Related to Healthcare Products or Services

Why We Ask:

As an accredited provider, we require your assistance to comply with accreditation guidelines and help us create high-quality Accredited Continuing Education (ACE) that is independent of industry influence. To participate in this educational activity, all individuals who have the ability to influence and/or control the content of this ACE activity must disclose all financial relationships with all companies - whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients - over the past 24 months. **To confirm your participation in this ACE activity, we ask that you complete and return this form within seven days of the receipt of this document.**

What to Disclose:

- There is no minimum financial threshold; you must disclose all financial relationships, regardless of the amount, with companies as described above; only disclose your own financial relationships, ***not*** those of your spouse or life partner.
- We ask you to disclose all financial relationships regardless of whether or not you view the relationships as relevant to the ACE activity. Staff will determine if the information that you provide is relevant to the topics of the ACE activity in which you will participate.
- Since healthcare professionals serve as the trusted authorities when advising patients, they must protect the learning environment from industry influence to ensure they remain true to their ethical commitments.
- If the staff determine that the financial relationships create a conflict of interest, the staff will determine the appropriate method of mitigation. Mitigation may involve but is not limited to an independent review of the content you develop (or if you are a planner, other methods will be utilized, including peer review of content by non-conflicted planners, etc.).
- Many healthcare professionals have financial relationships with companies as defined above. By identifying and mitigating relevant financial relationships, we will work together to create a protected space to learn, teach, and engage in scientific discourse free from the influence from organizations that may have an incentive to insert commercial bias into education.

Disclosure Form Required by The Standards for Integrity and Independence

This section to be completed by the Planner, Faculty, Author, Content Reviewer or Others Who May Control Educational Content:

Please disclose all financial relationships that you have had in the past 24 months with ineligible companies (see definition below). For each financial relationship, enter the name of the ineligible company and the nature of the financial relationship(s). There is no minimum financial threshold. We ask that you disclose all financial relationships, regardless of the amount, with ineligible companies.

A company is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. Types of organizations for which you must disclose your financial relationships are as follows: (1) biomedical startups that have begun a governmental regulatory approval process; (2) compounding pharmacies that manufacture proprietary compounds; (3) device manufacturers or distributors; (4) diagnostic labs that sell proprietary products; (5) growers, distributors, manufacturers or sellers of medical foods and dietary supplements; (6) manufacturers of health-related wearable products; (7) pharmaceutical companies or distributors; pharmacy benefit managers; and (8) reagent manufacturers or sellers.

Please complete the information below. Required fields are indicated with an asterisk (*) and must be completed.

Within the past 24 months, have you received financial support (in any amount) from an ineligible company (including employment,consulting, research grant support, honoraria, etc.)?*

- ○ Yes. In the past 24 months, I have an existing and/or have had a financial relationship with an ineligible company (list these relationships below).
- ○ No. In the past 24 months, I have not had a financial relationship with an ineligible company (leave below fields blank).

Enter the full name of the ineligible company, NO acronyms.

If the nature of your relevant relationship is not listed in the drop-down select "Other relevant financial and material interests," and edit the field to indicate the relevant interest.

If "Stocks or stock options, excluding diversified mutual funds" is selected, indicate whether company is public or privately traded in brackets, next to the name of the company.

Please specify your relationship:

Nature of the Financial Relationship*	Name of the Ineligible Company:*	Relationship Ended?*
None		Yes / No

Please specify your relationship:

Nature of the Financial Relationship*	Name of the Ineligible Company:*	Relationship Ended?*
None		Yes / No

Please specify your relationship:

Nature of the Financial Relationship*	Name of the Ineligible Company:*	Relationship Ended?*
None		Yes / No

Please specify your relationship:*

Nature of the Financial Relationship	Name of the Ineligible Company:*	Relationship Ended?*
None		Yes / No

Please specify your relationship:*

Nature of the Financial Relationship	Name of the Ineligible Company:*	Relationship Ended?*
None		Yes / No

Attestation

I have disclosed all financial relationships and I will disclose this information to learners.*

Yes No

The content and/or presentation of the information with which I am involved will promote quality or improvements in health care and will not promote a specific proprietary business interest of a commercial interest. Content for this activity, including any presentation of therapeutic options, will be balanced, evidence-based and commercially unbiased.*

Yes No

I understand that my presentation/content may need to be reviewed prior to this activity, and I will provide educational content and resources in advance as requested.*

Yes No

If I am providing recommendations involving clinical medicine, they will be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients. All scientific research referred to will conform to the generally accepted standard of experimental design, data collection and analysis.*

Yes No

I attest that any presentation on a new or evolving topic for which the level of evidence remains low or absent will be clearly identified within my presentation.*

Yes No

I attest that I will not include any content that advocates for unscientific approaches to diagnosis or therapy.*

Yes No

I attest that I will not include any content that promotes recommendations, treatment, or manners of practicing healthcare that are determined to have risks or dangers that outweigh the benefits or are known to be ineffective in the treatment of patients.*

Yes No

I attest that the above information is correct as of this date of submission.*

Yes No

I attest that the above information is correct as of this date of submission (sign below):*

Type your full name below to sign:*

Date*

_____

Please review your responses above to make sure all required fields (* indicates required) are completed before continuing.