

# Conflict of Interest DISCLOSURE FORM

- Complete name and address are required for faculty physician speaker credit

Speaker's Name:    Degree:   
Please Print First MI Last

Mailing Address:     
Mailing Address City State

Name and Date of CME Activity:

## Section A: OFF-LABEL USE OF PRODUCTS - Please complete the following as it applies to your presentation.

We require that you complete and return this form PRIOR to the educational activity.

### 1. Off-label Use (Product does not have an FDA-Approved indication for the use under discussion)

I do not anticipate discussing off-label uses of any commercial products in this educational activity.

I anticipate discussing the following off-label use(s) of the following product(s):

• Product:

• Off-label use to be discussed:

• Product:

• Off-label use to be discussed:

### 2. Investigational Products (Not approved by the FDA for any purpose)

I do not anticipate discussing use of any commercial products in this educational activity.

I anticipate discussing the following use(s) of the following product(s):

• Product:

• Use to be discussed:

• Product:

• Use to be discussed:

## Section B: AFFILIATION - CHECK ALL THAT APPLY:

I have no relationship with any commercial firm having products related to topics I will discuss at this conference.

My spouse/partner has no relationship with any commercial firm having products related to topics I will discuss at this conference

I (or my spouse/partner) have the following relationship(s) with

having products related to topics I will discuss at this conference:

My honorarium, speaker fee or expenses at this program are funded by such a company.

Representatives of such a company have assisted in the development of my presentation(s), handouts, slides, or other material I will use in my presentation(s).

I am a consultant for such a company.

I receive honoraria or speaker fees for other CME presentations from such a company.

I am employed by such a company.

Funding for my research is provided by such a company.

I or my spouse/partner have a relevant personal investment or other financial interest in such a company. (Please describe)

Other (Please describe)

## Certification:

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that as a requirement of the ACCME, any references to off-label uses of commercial or investigational products for indications not yet approved by the FDA must be disclosed to the audience during a live presentation (verbally or printed on evaluation). I understand that relevant financial relationships which I or my spouse/partner have with any commercial company whose product(s) I may discuss in my educational presentation must be disclosed prior to and will be listed in materials for CME certified activities.

Name (print)  Date

By checking this box I acknowledge that I have completed this document and the checked box is acting as my signature.

**FOR DEPARTMENT USE:** ACCME accreditation criteria (Element 3.3) require a means to identify and resolve potential conflicts or bias in presentations prior to CME education activities being delivered to learners. Therefore, this form must be signed by the CME conference/series coordinator and information provided as to the resolution of potential conflicts and/or bias. If no potential conflict or bias is disclosed, please indicate "no action necessary".

REVIEWED AND APPROVED BY:  Date:   No action required