To Activity director: *Fill in CME activity title and date (or fiscal year); participant's name; check role(s) of the participant; have completed (by each participant on the planning committee NOW, by your Faculty and Residents ASAP, by other speakers four months prior to the activity) and returned to you via your fax No. ____________ or ______________. Upon receipt, you are to send to the Office of CME and retain a copy.*

Dear Potential Participant, this form is required for participation on the planning committee, and/or as speaker, moderator, etc. for all CME accredited educational activities. Consequently, we ask that you fill in applicable information, check either No or Yes below, sign and return to the activity director immediately upon receipt.

<table>
<tr><td colspan="2">EXTERNAL or RSS TITLE (if RSS, dept. name; [ex., Medicine Grand Rounds, etc.]</td><td colspan="2">DATE or FISCAL YEAR</td></tr>
<tr><td colspan="2">SPEAKER'S TOPIC:</td><td colspan="2">DATE SPEAKER PRESENTS</td></tr>
<tr><td colspan="2">Participant's name (PRINT)
Address:

Phone: Email:
Check one: [ ] I accept participation as checked below.
[ ] I am unable to participate.</td><td colspan="2">I am (check one):
[ ] Resident Physician
[ ] Assistant Professor
[ ] Associate Professor
[ ] Professor
[ ] Other(specify)__________
in Dept./Division of __________</td></tr>
<tr><td>Check all that apply for this activity:
DIRECTOR of this activity [ ]
PLANNING COMMITTEE [ ]</td><td>SPEAKER [ ]
PANELIST [ ]
MODERATOR [ ]</td><td>U.S. Citizen?
Yes [ ]
No [ ]</td><td>[ ] HU CME ADVISORY COMMITTEE</td></tr>
</table>

CHECK YES OR NO AND SIGN IN APPROPRIATE SIGNATURE SPACE.

1. [ ] NO, neither **I nor my spouse/partner have/has any financial relationships with any commercial interests in the past 12 months, AND**

AS DIRECTOR AND/OR PLANNING COMMITTEE, I WILL:

[ ]to the best of my ability, ensure that any speaker or content I suggest is independent of commercial bias.

AS SPEAKER, I WILL:

[ ] Provide my slides and content in advance to allow for adequate peer review, if requested;

[ ]Use **generic names** to the extent possible; and if trade names are needed, those from several companies will be used; and will a**dvise the audience of the "off label" status** of drugs and devices, if discussed.

[ ] Not **accept** (and have not accepted) financial remuneration directly from any commercial supporter of this, or any other HUCM CME activity, nor any additional payments or reimbursements.

[ ] Uphold academic standards to insure balance, independence, objectivity and scientific rigor in my role in this activity.

(If you answered **NO**, sign, date and fax or email to activity director **IMMEDIATELY.**	DATE SIGNED
2. SIGNATURE	

\- -

OR, **IF YES**, COMPLETE 1-5 BELOW AND ON THE NEXT PAGE.

1. [ ] YES, I and/or my spouse/partner have or have had financial relationships in the past 12 months:

(If you answered YES, you must also complete the NEXT page and return both pages.)

DISCLOSURE FORM continued (Only if you answered YES on Page 1)

(Modified FY 2013)

2. FIRST, opposite the financial relationships below, include the names of the *commercial entities producing health care goods or services, consumed by, or used on, patients, with the exemption of non-profit or government organizations and non-health care related companies with which you or your spouse/partner have, or have had, a financial relationship within the past 12 months. For this purpose, we consider the financial relationships of your spouse or partner that you are aware of to be yours.* ***HU College of Medicine DOES NOT want to know how much you received.*** **(If you answered YES, you must complete and return both pages.)**

3. Nature of the Financial Relationship(s)	**Name(s) of Commercial Interest(s) or Non- Governmental Org.**
Grant/Research	
Consultant	
Speakers' Bureau	
Other (Specify)	

4. NEXT, *check the attestations BELOW, sign and fax or email to the activity director IMMEDIATELY.*

5. ATTESTATION: ***If you answered* YES *to the above, circle or check Y for Yes, N for No)***

Y N	I have disclosed all financial relationships to the CME provider (HUCM) and understand that this information will be disclosed to the audience by me via **PowerPoint** slide (and by the provider in printed materials and/or verbally).
Y N	The relationships identified above will not bias or influence the content of this or any HUCM CME activity in which I am involved.
Y N	I will provide my slides and content in advance to allow for adequate peer review, as required.
Y N	**If *it is* determined that my presentation cannot be made without discussing drugs of the company(ies) disclosed,** I will d*iscuss with the peer review board/director of CME the circumstances under which my presentation can be made. For clinical trials, I agree to discuss all drugs in this category.*
Y N	**If my presentation is on research conducted by commercial companies, I will provide a detailed outline at this time.**
Y N	I will use **generic names** to the extent possible; and if trade names are needed, those from several companies will be used.
Y N	I will a**dvise the audience of the "off label" status** of drugs and devices, if discussed.
Y N	I will n**ot accept/** have not accepted financial remuneration <u>directly</u> from any commercial supporter of this, or any other HUCM CME activity, nor any additional payments or reimbursements.

6. ATTESTATION (Sign here ONLY if you checked YES on the PREVIOUS PAGE.)	**DATE SIGNED**
SIGNATURE	

OFFICE OF CME USE ONLY- <u>DO NOT</u> WRITE BELOW. **– ATTESTATION OF RESOLUTION OF CONFLICT**

[ ] Conflict of the above was resolved prior to the participation as follows: _____

CME Director's Signature: <u>Debra White Coleman, M.D.</u> _____ **Date** _____