

## CME DISCLOSURE FORM

**ANYONE INVOLVED WITH THE CONTENT OF THE CME ACTIVITY MUST SIGN THIS FORM  
(Dept. chairs, committee members, residents, fellows, nurses, presenters, etc.)**

I understand that SUNY Downstate Medical Center endorses the Guidelines of the American Medical Association and the Standards of the Accreditation Council for Continuing Medical Education. Therefore, faculty or anyone involved with the presentation content for a CME activity must disclose to participants the presence of any relationships with commercial companies (healthcare related).

Significant financial relationships include receiving (from a company) research grants, consultancies, honorarium and travel, or other benefits or having self-managed equity in a company. Individuals with substantive conflicts of interest cannot plan or speak. Faculties are also expected to openly disclose any off-label, experimental, or investigational use of drugs or devices discussed in their presentation. Financial relationships of your spouse or partner, which you are aware of, for this purpose, are considered yours.

An individual who refuses to disclose relevant financial relationships will be disqualified from being a planning committee member, a teacher, or an author of CME, and cannot have control of, or responsibility for, the development, management, presentation or evaluation of the CME activity (ACCME Standard 2.3).

<b>Activity Title</b>	
<b>Title of Presentation</b>	
<b>Date</b>	
<b>Check one:</b> <input type="checkbox"/> Course Director <input type="checkbox"/> Faculty <input type="checkbox"/> Moderator <input type="checkbox"/> Planning Committee <input type="checkbox"/> Speaker/Presenter <input type="checkbox"/> Other:	
<b>Name</b>	
<b>Degree and Credentials</b>	
<b>Title</b>	
<b>Organization</b>	
<b>Address</b>	
<b>City/State/Zip</b>	
<b>Phone</b>	
<b>E-mail</b>	

### DISCLOSURE OF FINANCIAL RELATIONSHIPS

**1. Within the past twelve months, I and/or my spouse/significant other have received support from or had a relationship with a/the following commercial interests (indicate all that apply). Disclosure should include relationships in any amount.**

<input type="checkbox"/> No	<input type="checkbox"/> Yes, (if yes provide complete information)					
Commercial Interest	Speakers bureau	Consultant, advisor	Stock ownership*	Research grant**	Employment affiliation	Royalties, patents
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* not including stocks owned in a managed portfolio

**Please describe any additional relevant disclosure below:**

**2. I will discuss a drug or medical device that has not been approved by the FDA.**

No <input type="checkbox"/>	Yes <input type="checkbox"/> (Describe)
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**3. I will be using slides, scripts, or other teaching material that were provided from a commercial source.**

No <input type="checkbox"/>	Yes <input type="checkbox"/> (Describe)
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**4. Content Validation/Resolution of Conflicts of Interest**

**I attest to the following:**

Yes <input type="checkbox"/>	No <input type="checkbox"/>	I understand that the information presented to the learner must be unbiased, scientifically balanced, and based on best available evidence and best practices in medicine. I agree to present all reasonable clinical alternatives when making practice recommendations. I attest that relationships with commercial interests will not influence or bias my presentation and/or planning of the CME activity.
Yes <input type="checkbox"/>	No <input type="checkbox"/>	All scientific research referred to, reported, or used in support or justification of patient care recommendations will conform to the generally accepted standards of experimental design, data collection, and analysis.
Yes <input type="checkbox"/>	No <input type="checkbox"/>	I attest that I will not accept any payment or reimbursement for this presentation directly from any commercial interest. I understand that all payments and reimbursements must be made by the accredited provider or authorized educational partner.

**I agree to:**

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Avoid the use of trade names in my presentation. If I determine that it is important to clarify via the use of trade names, trade names from all available companies should be included, not just trade names from a single company.
Yes <input type="checkbox"/>	No <input type="checkbox"/>	If requested, provide appropriate peer-reviewed journal references which support clinical or practice recommendations. I understand that my CME presentation may be evaluated by participants for fair balance (e.g. degree of commercial bias) and that enduring materials (if applicable) will be peer-reviewed for fair balance and validation of content and may be edited accordingly.
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Disclose to the program audience when products/services are not labeled for the use under discussion or when the products are still under investigation.
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comply with patient confidentiality requirements as outlined in the Health Insurance Portability and Accountability Act (HIPAA)
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Obtain the necessary copyright permission(s) if any portion of my CME activity materials that I prepare is not my original work or for which I do not hold the copyright.

**5. Abstract of Presentation – Brief description of your presentation**

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**6. Learning Objectives –**

List at least 3 expected learning outcomes in terms of knowledge, skills, attitudes and professional practice.  
What will the participant be able to do after viewing your presentation?

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You may email your CV and/or Slide presentation to [ocme@downstate.edu](mailto:ocme@downstate.edu)

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Signature

\_\_\_\_\_  
Date