CONFLICT OF INTEREST DISCLOSURE FORM

Children's Hospital of The King's Daughters Continuing Medical Education – Office (757) 668-8942 - Facsimile (757) 668-7122

SECTION 1

In compliance with the updated Standards for Commercial Support of Continuing Medical Education, it is the policy of CHKD Continuing Medical Education to insure balance, independence, objectivity, and scientific rigor in all CHKD sponsored CME activities. All persons involved in the planning, and all faculty presenters (including moderators, authors and editors) are expected to disclose all relevant financial relationships described below.

Failure or refusal to do so will prohibit presenting at or participating in planning this activity.

Title of Program:	*Program Location:*
Title of Presentation(s):	*Live Presentation Date:* *OR, Is this an enduring material?* ☐ YES
Please indicate your role in this activity: ☐ Presenter ☐ Moderator ☐ Course Director ☐ Author/Editor ☐ Planning Committee Member ☐ Activity Coordinator ☐ CME Committee Member	*PRINT Name:* *Title/Position:* *Phone:* *Fax:* *Email Address:*

SECTION 2

Please provide the following information regarding relationships you or your spouse/partner currently hold, or held within the last 12 months with commercial interests that produce, market, re-sell, or distribute health care goods or services consumed by, or used on, patients which are the subject of your presentation/participation in this activity. Please note: Refusal to provide this disclosure will disqualify you from presenting at or participating in this activity.

During the last 12 months, have you or your spouse and/or partner had a personal financial relationship with the manufacturer or provider of any product or service relevant to your proposed presentation/ submission or your participation as a planner?

☐ YES *(Proceed to Sections 3)*

Please list all relationships here and use separate sheet if needed.

☐ NO *(Skip to Section 5)*

SECTION 3

COMMERCIAL l INTEREST	NATURE OF RELEVANT FINANCIAL RELATIONSHIP
Section 3 *Add additional sheets if necessary*	**Employee, grants/research support recipient, board member, advisor or review panel member, consultant, independent contractor, stock shareholder (excluding mutual funds), speaker's bureau, honorarium recipient, royalty recipient, holder of intellectual property rights, or other:**
Name of Company: *Please print legibly*	**Identify the nature of each relationship referring to list above.**
1.	
2.	
3.	
4.	
5.	

SECTION 4

RESOLUTION OF CONFLICT OF INTEREST*

If you answered "YES" in Section 2, how do you choose to resolve the conflict?

Presenters/Authors/Editors: (check all that apply)

☐ I will support my presentation and clinical recommendations with the best evidence available from all sources.

☐ I will not make any clinical recommendations regarding products or service.

☐ I have divested myself of this financial relationship

Additionally, I will:

- Disclose to the audience when products/services are not approved by the FDA for the use under discussion or when the products are still under investigation.
- Not accept any payment or reimbursement for this presentation directly from any commercial interest.
- Not use trade names in my presentation. If use of trade names is necessary for clarification, all available commercial products in the same class will also be included.

***CHKD CME reserves the right to conduct peer review of instructional materials.**

Planning/CME Committee Members , Activity Coordinators, Course Directors, Moderators:

☐ To the best of my ability, my financial relationships with commercial interests will not affect any speakers or content over which I exert control.

☐ I will recuse myself from planning activity content in which I have a conflict of interest.

SECTION 5

DECLARATION

I will uphold academic standards to insure balance, independence, objectivity, and scientific rigor in my role in planning, development or presentation of this CME activity and I will support content and clinical recommendations with the best evidence available from all sources. In addition, I agree to comply with the requirements to protect health information under the Health Insurance Portability & Accountability Act of 1996 (HIPPA).

Signature _____ **Date** _____

Activity Coordinator _____ **Date** _____