**Continuing Education Planner Disclosure Form**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CE Sponsor/Organization/Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DISCLOSURE OF FINANCIAL RELATIONSHIPS WITHIN 12 MONTHS OF DATE OF THIS FORM

I have a financial relationship or other affiliation with a proprietary entity producing health care goods or services.  Please check the relationship(s). (Check all that apply)

* Research Grants
* Speakers’ Bureaus\* (see \* below)
* Ownership
* Consultant for Fee
* Stock/Bond Holdings (excluding mutual funds)
* Employment
* Partnership
* Others (please list) \_\_\_\_\_

Please indicate the names of the organizations with which you have a financial relationship or interest, and the specific clinical areas that correspond to the relationship.  If more than four relationships please list on separate page:

|  |  |
| --- | --- |
| Organization with which Relationship Exists | Clinical Area Involved |
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |

* Did you participate in company-provided speaker training related to the topics planned?
  + YES or No
* Did the company provide you with slides of the presentation?
  + Yes or No
* When serving as a program planner for this CE event, will you use slides/content provided or data obtained from commercial speaker training?
  + Yes or No

If I have indicated a financial relationship or interest, I understand that this information will be reviewed to determine whether a conflict of interest may exist, and I may be asked to provide additional information.  I understand that failure to disclose, false disclosure, or inability to resolve conflicts of interest will require the CE Provider to identify a replacement.  I also attest that any faculty identified by myself for this program was chosen independently without involvement of any commercial interest.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_           Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Electronic Signature accepted:  Typed signature with date indicates electronic verification of the information provided.)