

Division of Continuing Medical Education - University of Iowa Carver College of Medicine

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS

As a provider of CME accredited by the ACCME, The UI Carver College of Medicine must ensure balance, independence, objectivity, and scientific rigor in all continuing education activities it sponsors. The College places a higher priority on the health and well being of the public than on individuals' personal economic interests. Speakers and program planners for these activities must disclose any relevant financial interests or other relationships with the manufacturer(s) of commercial products and/or provider(s) of commercial services discussed in an educational presentation. **ANYONE WHO REFUSES TO DISCLOSE WILL BE DISQUALIFIED FROM PARTICIPATING IN A CME ACTIVITY.** Please disclose relevant financial relationships of your partner/spouse as well.

Name of Person Disclosing: _____

Program Title: _____ **Program Date:** _____
 (Example: 'Pediatric Postgraduate Course', 'Internal Medicine Grand Rounds', etc.)

1. **Within the past 12 months, I have had NO financial relationships with proprietary entities that produce health care goods and services.** Proceed to question 3.
2. **Within the past 12 months, I have had financial relationships with proprietary entities that produce health care products and services.** These financial relationships (which will be disclosed to the audience) are:

<u>Financial Interest</u>	<u>Company or Companies</u>
Speakers' Bureau	_____
Consultant	_____
Grant/research support	_____
Major Stockholder	_____
Other (explain)	_____

3. **If applicable, I will disclose to the audience unlabeled use of a commercial product or an investigational application not yet approved for use by the Food and Drug Administration (FDA).**
4. **I agree to abide by the Content Validation Guidelines (p. 2) and uphold academic standards to ensure balance, independence, objectivity, and scientific rigor in my role in the planning, development or presentation of this CME activity.**

Signature of Person Disclosing _____
Date

Return or fax form to: _____

For Office Use Only: The person responsible for the content of the activity (e.g. Course Director) fills out this section.

Conflicts of interest for this individual were resolved by: (check all that apply)

- | | |
|--|---|
| Omitting product recommendations | Requesting COI Advisory Committee Review |
| Requiring only evidence based medicine studies | No relationships / no relevant relationships |
| Choosing another topic or another speaker | Previewing Content of Presentation – No commercial bias |

Notes: _____

Signature of Reviewer: _____ **Date:** _____

