**University of California, San Diego School of Medicine**

**DISCLOSURE FORM**

It is the policy of the University of California, San Diego School of Medicine to ensure balance, independence, objectivity and scientific rigor. All persons involved in the selection, development and presentation of content are required to disclose any real or apparent conflicts of interest. All conflicts of interest will be resolved prior to an educational activity being delivered to learners through one of the following mechanisms 1) altering the financial relationship with the commercial interest, 2) altering the individual’s control over CME content about the products or services of the commercial interest, and/or 3) validating the activity content through independent peer review. All persons are also required to disclose any discussions of off label/unapproved uses of drugs or devices. Persons who refuse or fail to complete this form will be disqualified from participating in the CME activity. Participants will be asked to evaluate whether the speaker’s outside interests reflect a possible bias in the planning or presentation of the activity.

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| **CME Activity Title:** | ENT Nights |
| **Title of Presentation:** |         |
| **Live Presentation Date:** |       | **-or-** | [ ]  **Home Study/Enduring Materials** |
| **Please indicate your role in this CME activity:**  | [ ]  Presenter | [ ]  Author | [ ]  Course Director | [ ]  Moderator | [ ] Planner/Planning Committee Member |
| **Name:** |       | **Title:** |       |
| **Phone:** |       | **E-mail:** |       |

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| **DISCLOSURE** |

[ ]  [ ]  Have you (or your spouse/partner) had a personal financial relationship **in the last 12 months** with **YES NO** a commercial interest that produces, markets, re-sells, or distributes health care goods or services consumed by, or  used on patients that will be discussed in this CME activity (planner) or in your presentation (speaker/author)? **If NO, skip to DECLARATION section below.** **If YES, please list your disclosures *and* approaches to resolutions below.**  |

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| **Commercial Interest** | **Nature of Relevant Financial Relationship** |
| **Name****of****Company** | **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** |
| **1.** |       |       |
| **2.** |       |       |
| **3.** |       |       |
| **4.** |       |       |
| **5.** |       |       |
|  **The following mechanisms have been identified to resolve conflicts of interest. Please check all that apply:**  Presenter/Author/Course Director/Moderator[ ]  I will support my presentation and clinical recommendations with the “best available evidence” from the medical literature. See suggested sources of best evidence at [www.aafp.org/x3139.xml](http://www.aafp.org/x3139.xml). [ ]  I will refrain from making recommendations regarding products or services, e.g., limit presentation to pathophysiology, diagnosis,  and/or research findings.[ ]  I will recommend an alternative presenter for this topic for the planning committee’s consideration.[ ]  I will submit my presentation in advance to allow for adequate peer review.[ ]  I will or have divested myself of this and/or these financial relationship(s).Planner/Planning Committee Member [ ]  To the best of my ability, I will ensure that any speakers or content I suggest is independent of commercial bias. [ ]  I will recuse myself from planning activity content in which I have a conflict of interest..Additional information may be requested to resolve conflicts of interest. Disclosure will be made to participants prior to the educational activity. |

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| **DECLARATION** |

**1.** I will uphold academic standards to ensure balance, independence, objectivity, and scientific rigor in my role in the planning, development or presentation of this CME activity. **2.** I agree to comply with the requirements to protect health information under the Health Insurance Portability & Accountability Act of 1996. (**HIPAA**)**3.** I will inform learners when I discuss or reference unapproved or unlabeled uses of therapeutic agents or products. Signature       Date        |

**Please return this form to the activity organizer. If you have questions about this policy, please contact CME (858) 534-3940. (July 2015)**