



**Continuing Education Faculty Disclosure and Consent Form**

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

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Contact email: \_\_\_\_\_

Presentation Title: \_\_\_\_\_

I have or an immediate family member has 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    | Stock/Bond Holdings (excluding mutual funds) |
| Speakers' Bureaus* | Employment                                   |
| Ownership          | Partnership                                  |
| Consultant for Fee | 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

- |   |     |    |
|---|-----|----|
| ❖ Did you participate in company-provided speaker training related to your proposed topic?            | Yes | No |
| ❖ Did the company provide you with slides of the presentation in which you were trained as a speaker? | Yes | No |
| ❖ Did the company pay the travel/lodging/other expenses?  | Yes | No |
| ❖ Did you receive an honorarium or consulting fee for participating in this training?                 | Yes | No |

- ❖ Have you received any other type of compensation from any company? Yes    No  
Please specify: \_\_\_\_\_
- ❖ When serving as faculty for the CE Provider, will you use slides provided by a proprietary entity for your presentation/handout materials? Yes    No
- ❖ Will your topic involve information or data obtained from commercial speaker training? Yes    No

**DISCLOSURE OF UNLABELED/INVESTIGATIONAL USES OF PRODUCTS**

The content of my materials(s)/presentation(s) in the CE activity **will not** include discussion of unapproved or investigational uses of products or devices.

The content of my material(s)/presentation(s) in the CE activity **will** include discussion of unapproved or investigational uses of products or devices. Verbal disclosure will be made during the presentation(s).

Please specify off-label or investigational use: \_\_\_\_\_

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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
SSN or Tax ID# (required for tax reporting purposes)

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

**CONSENT**

Purpose of use/reproduction: inclusion in the: AOCD Annual Meeting Brochure and Compilation CD of Lectures.

I do Consent

I do not Consent

**Please mail or fax this completed form to:**

Marsha A. Wise, BS, Executive Director  
American Osteopathic College of Dermatology  
PO Box 7525  
Kirksville, MO 63501  
800.449.2623(toll-free)  
660.627.2623(fax)