JOINT PROVIDERSHIP | amda THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

Financial Relationship Disclosure Form

Name: _____ ☐ Planner ☐ Speaker/Faculty ☐ Staff ☐ Reviewer ☐ Author/Writer ☐ Moderator

Presentation Title(s)
if Applicable _____

Activity Title: _____ Date of Activity: _____

As a prospective planner or faculty member, we would like to ask for your help in protecting our learning environment from industry influence.

Please disclose **all financial relationships** that you have had in the **past 24 months** with ineligible companies (see definition below). For each financial relationship, enter the name of the ineligible company and the nature of the financial relationship(s). There is no minimum financial threshold; we ask that you disclose all financial relationships, regardless of the amount, with ineligible companies. You should disclose all financial relationships regardless of the potential relevance of each relationship to the education.

Nature of Financial Relationship	Name of Ineligible Company(s)	Has the Relationship Ended?
EX: Everything below and Royalties, IP, Independent Contractor, Founder/Co-Founder	An **ineligible company** is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.	Please check the box if the relationship has ended.

☐ I have not had **any** financial relationships with any ineligible companies in the past 24 months

	Check the appropriate boxes below for each relationship	*Indicate the name of the ineligible company*	*Check the box if the relationship has ended*
☐	Advisory Board		☐
☐	Consultant		☐
☐	Speaker's Bureau		☐
☐	Grant/Research Support *(principal investigators)*		☐
☐	Honoraria		☐
☐	Stock Shareholder (*exclude diversified funds*)		☐
☐	Full-time/Part-time Employee		☐
☐	Other:		☐

Will you discuss any off-label/investigative (unapproved) use of a commercial product/device or topic or treatment with a lower (or absent) evidence base?
Any drug or medical device is being used "off-label" if the described use is not set forth on the product's approval label.

☐ No ☐ Yes, Please Describe:

Agreement and Responsibilities:

Planners and Reviewers:

- I agree to recuse myself or accept a request to recuse myself from planning or reviewing educational content that is related to any conflict indicated above.
- I will uphold academic standards to ensure balance, independence, objectivity, and scientific rigor in my role in the planning and review of this CME activity.

Presenters and Faculty:

- CME must give a balanced view of therapeutic options. Use of generic drug names contributes to impartiality. Also, if my CME educational material or content includes trade names then trade names from several companies should be used where available, not just trade names from a single company.
- I agree to comply with the requirements to protect health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).
- I agree to provide verbal disclosure prior to my presentation at the activity to include relevant financial relationships and the discussion of any off-label use of medications or treatments.

☐ I agree to the Planner and/or Faculty responsibilities.

I attest that the above information is correct as of this date of submission.

_____
Type or sign and date above

AMDA Conflict of Interest Policy

It is the policy of AMDA-The Society for Post-Acute and Long-Term Care Medicine (AMDA) to ensure balance, independence, objectivity and scientific rigor in all CME activities. CME content will be evidence based and free of commercial bias. Anyone engaged in content development, planning or presentation must complete this form. Persons who fail to complete this form may not participate in the planning or presenting of this accredited education. All identified relevant financial relationships will be identified, mitigated and disclosed to learners. If you have any questions regarding the AMDA CME Conflict of Interest Policy, please call 410-740-9743.

AMDA complies with the requirements of the National Physician Payment Transparency Program OPEN PAYMENTS (Physician Payments Sunshine Act).