I. GENERAL INFORMATION

1. (A) As a provider of Continuing Medical Education accredited by the Accreditation Council for Continuing Medical Education, the USCSOM-PHR CME ORGANIZATION must ensure balance, independence, objectivity, and scientific integrity in all its educational activities. (B) We must also be able to show that everyone who is in a position to control the content of an educational activity has disclosed all relevant financial relationships with any commercial interest to the provider and that any conflicts are resolved.

Title of CME Activity: ____________________________

Date(s): ____________________________ Location: ____________________________

Name: ____________________________

Role in Activity: Planning Committee_____ Moderator______ Speaker______ Author______ Other _______

Title of Presentation(s) (if known): ____________________________________________________________

By signing this document, you agree to the following elements as expected of individuals involved in the planning and implementation of educational activities sponsored by the USCSOM-PHR CME Organization. Please check the box at the end of each statement to indicate your agreement. I agree to:

For Planning Committee Members and Moderators


For Speakers and Authors

1. Address the specified objectives;
2. Deliver balanced and objective evidence-based content;
3. Present the source and type or level of evidence to participants;
4. Discuss all reasonable clinical alternatives when making practice recommendations;
5. Disclose off-label /investigative uses of commercial products/devices.

II. DISCLOSURE

☐ Yes ☐ No Have you (or your spouse/partner) had a relevant financial relationship in the past 12 months with any proprietary entities producing health care goods or services with the exemption of non-profit or government organizations and non-health care related companies?

If NO, please sign and date here. ______________________________________________________________

Signature Date

If YES, please disclose your relationships/affiliations and sign and date the form below.

<table>
<thead>
<tr>
<th>Commercial Interest</th>
<th>Nature of Relevant Financial Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Company</td>
<td>Employee, Grants/Research Support recipient, Board Member, Advisor or Review Panel member, Consultant, Independent Contractor, Stock Shareholder (excluding mutual funds), Speakers’ Bureau, Honorarium recipient, Royalty recipient, Holder of Intellectual Property Rights, or Other</td>
</tr>
</tbody>
</table>

1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  

Therefore, in light of the relationships/affiliations you designated, WE ASK THAT YOU ATTEST to the following:

1. These relationships/affiliations will not bias or otherwise influence my involvement in the activity;
2. Practice recommendations I make relevant to the companies with whom I have relationships/affiliations will be supported by the best available evidence or, absent evidence, will be consistent with generally accepted medical practice.
3. I will comply with the listed elements as outlined in Section I above, and will submit the required documentation within the required timeframe(s).

Signature Date
FOR CME OFFICE USE – Conflict of Interest identified and resolved by the following methods:

Participant approved for the activity:  □ Yes  □ No  □ Pending

Decision Made By: ________________________________  Date: ________________________________

Concur: _____ Yes  _____ No  By: ________________________________

Revised 8/05