

CME/CE Faculty Disclosure - 1st Annual Virtual Symposium on

Prenatal-onset Group B Strep Disease

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**Biographical Information & Conflict of Interest Statement**

ANYONE INVOLVED WITH THE CONTENT OF CONTINUING EDUCATION ACTIVITY MUST SIGN THIS FORM.

Star Legacy Foundation and Group B Strep International endorse the Guidelines of the American Medical Association and the Standards of the Accreditation Council for Continuing Medical Education as well as the guidelines and policies of the American Nurses Association. Therefore, faculty or anyone involved with the presentation content for a CME activity must disclose to participants the presence of any relationships with commercial companies (healthcare related). All relevant financial relationships of any amount include receiving (from a company) research grants, consultancies, honorarium and travel, or other benefits or having self-managed equity in a company. A commercial interest is any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.

Presenters are also expected to openly disclose any off-label, experimental, or investigational use of drugs or devices discussed in their presentation. Financial relationships of your spouse or partner, which you are aware of, for this purpose, are considered yours. Therefore, if applicable, disclosure of the relevant financial relationships of the spouses or partners of everyone in a position to control continuing education content is also needed for compliance. Refusal to provide a conflict of interest disclosure will void any invitation to present at the 1st Annual Virtual Symposium on Prenatal-onset Group B Strep Disease.

\*Date

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**Demographic Information**

\*Name

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\*Street Address

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\*State/Province

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\*Country

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\*Zip/Postal Code

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\*Email

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\*Phone

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\*Degree/Credentials

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Title

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Which institutions are you affiliated with?

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Specialty/Sub-specialty

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**Disclosure of Financial Relationships**

\*Within the past twelve months, I and/or my spouse/significant other have received support from or had a relationship with a/the following commercial interests (indicate all that apply). Disclosure should include relationships in any amount.

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| --- | --- |
|  | Yes |
|  | No |

\*If yes, please list and describe:

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**Unapproved Drugs and Devices**

If you plan to discuss the use of a drug or a medical device that has not been approved by the FDA, please describe:

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**Fair Balance, Independent Content Validation, Level of Evidence**

\*I understand that the information presented to the learner must be unbiased, scientifically balanced, and based on best available evidence and best practices in medicine. I agree to present all reasonable clinical alternatives when making practice recommendations. I attest that relationships with commercial interests will not influence or bias my presentation and/or planning of the continuing education activity.

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|  | Yes |
|  | No |

Comment:

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\*All scientific research referred to, reported, or used in support or justification of patient care recommendations will conform to the generally accepted standards of experimental design, data collection, and analysis.

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| --- | --- |
|  | Agree |
|  | No |

\*I attest that I will not accept any payment or reimbursement for this presentation directly from any commercial interest. I understand that all payments and reimbursements must be made by the accredited provider or authorized educational partner.

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| --- | --- |
|  | Agree |
|  | No |

\*I agree to avoid the use of trade names in my presentation. If I determine that it is important to clarify via the use of trade names, trade names from all available companies should be included, not just trade names from a single company.

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|  | Agree |
|  | No |

\*If requested, I will provide appropriate peer-reviewed journal references which support clinical or practice recommendations. I understand that my continuing education presentation may be evaluated by participants for fair balance (e.g. degree of commercial bias) and that enduring materials (if applicable) will be peer-reviewed for fair balance and validation of content and may be edited accordingly.

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|  | Agree |
|  | No |

\*I will disclose to the program audience when products/services are not labeled for the use under discussion or when the products are still under investigation.

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|  | Agree |
|  | No |

\*I will comply with patient confidentiality requirements as outlined in the Health Insurance Portability and Accountability Act (HIPAA)

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|  | Agree |
|  | No |

\*I will obtain the necessary copyright permission(s) if any portion of my CME activity materials that I prepare is not my original work or for which I do not hold the copyright.

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|  | Agree |
|  | No |

**Signature**

**Entering your name in the text box below constitutes an electronic signature.**

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