ASSOCIATION OF PHYSICIANS OF PAKISTANI DESCENT OF NORTH AMERICA

Financial Relationships Disclosure Form

For Activity Directors, Faculty, Committee Members, and Staff

Organizations accredited by the Accreditation Council for Continuing Medical Education (ACCME) are required to identify and resolve all potential conflicts of interest with any individual in a position to influence and/or control the content of CME activities. A conflict of interest will be considered to exist if: (1) the individual has a 'relevant financial relationship'; that is, he/she has received financial benefits of any amount, within the past 12 months, from a commercial interest' (an entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients), and (2) the individual is in a position to affect the content of CME regarding the products or services of the commercial interest.

All individuals in a position to influence and/or control the content of APPNA CME activities are required to disclose to the APPNA, and subsequently to learners: (1) any relevant financial relationship(s) they have with a commercial interest, or (2) if they do not have a relevant financial relationship with a commercial interest.

Failure to provide disclosure information in a timely manner prior to the individual's involvement will result in the disqualification of the potential Activity Director, Faculty, Committee Member, or Staff, from participating in the CME activity.

Title of CME activity: _____

Title of Presentation: _____

Name: _____ Date of the Meeting: _____

Please check one to indicate your role: ☐ Faculty ☐ Activity Director ☐ Staff

☐ Committee Member (specify :_____) ☐ Other (specify :_____)

Phone Number: _____ E-mail: _____

I. DISCLOSURE OF FINANCIAL RELATIONSHIPS WITHIN 12 MONTHS OF DATE OF THIS FORM

☐ Neither I, nor any member of my immediate family, has a financial relationship or interest (currently or within the past 12 months) with any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.

OR

☐ Either I, or any immediate family member has a financial relationship or interest (currently or within the past 12 months) with any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients. The financial relationships are identified as follows (if needed, attach an additional list):

Relevant Financial Relationship(s) Related to Your Content (check all that apply)

Commercial Interest(s)(any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients).	**Research Grant (including funding to an institution for contracted research)**	**Speaker's Bureau**	**Stocks/Bonds (excluding Mutual Funds)**	**Consultant**	**Other (Identify)**
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

II. DISCLOSURE OF OFF-LABEL (UNAPPROVED)/INVESTIGATIONAL USES OF PRODUCTS

APPNA requires faculty/planners to disclose when they plan to discuss or demonstrate pharmaceuticals and/or medical devices that are not approved by the FDA and/or medical or surgical procedures that involve an unapproved or "off-label" use of an approved device or pharmaceutical.

☐ I do intend to discuss an unapproved/investigative use of a commercial product/device and will disclose such references to learners.

☐ I do not intend to discuss an unapproved/investigative use of a commercial product/device.

☐ I affirm that the foregoing information is complete and truthful, and I agree to notify APPNA immediately if there are any changes or additions to my relevant financial relationships. During my participation in this activity, I will wholly support APPNA's commitment to conducting CME activities with the highest integrity, scientific objectivity, and without bias. I agree that I will not accept any honoraria, additional payments or reimbursements beyond what has been agreed upon to be paid directly by APPNA in relation to this educational activity.

Signature: _____ Date: _____