

**CALL FOR PRESENTATIONS**  
**2016 Missouri Department of Mental Health's**  
**Spring Training Institute (STI)**  
June 2-3 2016  
Tan-Tar-A Resort, Osage Beach, Missouri

***Please complete this application; save it as lastname\_titlekeyword.pdf and e-mail it to STI@MIMHTraining.com by October 31, 2015***

Name	
Home Address	Agency
City	Work Address
State                      Zip	City
Daytime Phone	State                      Zip
E-Mail Address	Profession  Degree and Where Earned

**Presentation Title (be brief; clearly state the subject of your presentation):**

**Brief Biographical Sketch of Presenter(s) in 100 words or less. For accreditation purposes, presenters should hold an advanced degree, should indicate appropriate training with regard to topic presented.**

**Presentation Description:**

**What is the subject area of your talk?**

**What training need in your field do you see this presentation filling?**

### **Learning Objectives (3):**

The global conference objectives are:

1. Review fundamental knowledge of behavioral health, substance use, and disability.
2. Describe established approaches and emerging trends in the services required to support patients and families of patients with behavioral health and/or substance use management needs.
3. Understand the particular strategies used in the support of military personnel, persons experiencing trauma, persons facing substance use issues, persons with eating disorders, and persons facing co-occurring disorders.
4. Review a variety of therapeutic approaches to meet the behavioral health needs of their clients and their families.

Please note which one or more of these objectives applies to your presentation and provide three learning objectives of your own.

### **Intellectual Property**

As you prepare your presentation materials, please note that it is our intention to place these on the conference website for download by participants, and also to distribute them on a special conference flash drive which is handed out at registration.

As a University-based operation, we place a high regard on content originality and the ownership of intellectual property. Please be sure that the presentation materials you provide to us do not contain anything that might violate another person's rights.

I warrant and represent that all materials I propose to present are original and do not infringe on the intellectual property rights of others. I have read and understand the above notice regarding the conference-related uses of my materials by the Missouri Institute of Mental Health

**Please complete the next page of this application and email the entire form to STI@MIMHTraining.com by October 31, 2015. Save as lastname\_titlekeyword.pdf.**

# MU Continuing Medical Education and MU Nursing Outreach Biographical and Conflict of Interest Form

Title of Educational Activity: \_\_\_\_\_ Education Activity Date: \_\_\_\_\_

Role in Educational Activity: (Check all that apply)

\_\_\_\_ ANCC/MONA Nurse Planner (Farrah or Designee) \_\_\_\_ Content Reviewer \_\_\_\_ Planning Committee Member  
\_\_\_\_ Author \_\_\_\_ Speaker/Presenter \_\_\_\_ RN Subject Matter Expert \_\_\_\_ Other - Describe: \_\_\_\_\_

## Section 1: Demographic Data

Name with Credentials/Degrees: \_\_\_\_\_

If RN, Nursing Degree(s): \_\_\_\_ AD \_\_\_\_ Diploma \_\_\_\_ BSN \_\_\_\_ Masters \_\_\_\_ Doctorate

If RN, do you hold a current, valid license to practice as an RN? \_\_\_\_ Yes \_\_\_\_ No

If Physician: \_\_\_\_ MD \_\_\_\_ DO \_\_\_\_ Other: \_\_\_\_ If Other Health Professional: Please list credentials/degrees: \_\_\_\_\_

Current Employer and Position/Title: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

## Section 2: Expertise

Please describe professional experience and years of education specific to this educational activity. This information needs to explain why you are qualified to plan and/or speak at this particular program.

Nurses: Please summarize information from your curriculum vitae/resume' in lieu of attaching the entire document. This is required by our accrediting organization. This information may also be used to introduce you. Physicians: You may attach a short bio in lieu of summarizing your expertise.

## Section 3: Actual/Potential Conflict of Interest

The potential for conflicts of interest exists when an individual has the ability to control or influence the content of an educational activity and/or has a relevant financial relationship with a commercial interest,\* the products or services of which are pertinent to the content of the educational activity.

\*Commercial interest, as defined by ACCME/ANCC, is any entity producing, marketing, reselling, or distributing healthcare goods or services consumed by or used on patients, or an entity that is owned or controlled by an entity that produces, markets, resells, or distributes healthcare goods or services consumed by or used on patients.

Is there an actual, potential or perceived conflict of interest for yourself or spouse/partner? \_\_\_\_ Yes \_\_\_\_ No

If yes, indicate name of commercial interest (company or organization) \_\_\_\_\_

AND complete the table below for all actual or potential conflicts of interest\*\*:

Please check all that apply

\_\_\_\_ Employee \_\_\_\_ Royalty \_\_\_\_ Stockholder \_\_\_\_ Research Support \_\_\_\_ Speakers Bureau \_\_\_\_ Consultant

Other \_\_\_\_\_

\*\* All conflicts of interest, including potential ones, must be resolved prior to the planning, implementation, or evaluation of the continuing education activity.

## Section 4: Statement of Understanding

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that relevant financial relationships which I or my spouse/partner have with any commercial company whose product(s) I may discuss in my educational presentation must be disclosed prior to and will be listed in materials for CME certified activities.

An "X" in the box below serves as the electronic signature of the individual completing this Biographical/ Conflict of Interest Form and attests to the accuracy of the information given above.

\_\_\_\_ Electronic Signature Completed by (name and credentials): \_\_\_\_\_ Date: \_\_\_\_\_