MD Continuing Medical Education and MD Nursing Outreach
Biographical and Conflict of Interest Form

Title of Educational Activity: _____ Education Activity Date: _____

Role in Educational Activity: (Check all that apply)

____ MD/CME/Nurse Planner (Parent or Designee) ____Content Reviewer ____Planning Committee Member

____Author ____Speaker/Presenter ____ All Subject Matter Expert ____Other - Describe: _____

Section 1: Demographic Data

Name with Credentials (Degrees): _____

If MD, Nursing Degree(s): ____AB ____Diploma ____BSN ____Masters ____Doctorate

If MD, do you hold a current, valid license to practice as an MD? ____Yes ____No

If Physician: ____AB ____MD ____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 on this particular program.

Notes: 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. Reminders: 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 any 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: _____
(MD 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 this 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.

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

____Electronic Signature Completed by (name and credentials): _____ Date: _____

FOR DEPARTMENT USE: ACCME accreditation criteria (Element 3.1) requires someone to identify and resolve conflicts of interest prior to CME education activities being delivered to learners. Therefore, this form must be signed by the CME conference/series coordinator and information provided as to the resolution of potential conflicts and/or bias. If no potential conflict or bias is disclosed, please indicate "no action necessary".

APPROVED BY:

____Electronic Signature Signature: _____ Date: _____

Action Required - if no conflict is disclosed, please note "no action Necessary": _____