

PRE-PLANNING CME-CE Disclosure Form: This form must be completed by all Planners, Course Directors, Managers, and Independent Reviewers of Content, PRIOR TO the commencement of any activity planning, or accreditation decision. Submission of disclosures is a pre-requisite to any decision by NYU-LISoM CME to recognize activities for CME credit. Submission of Disclosures does not obligate or guarantee that an activity will be recognized for CME credit.

Name _____ E-mail _____
 Mobile Phone _____ NYU Employee ___Y___N
 Job Title: _____

Activity Name: _____ Today's Date: _____

Please indicate your role in this CME-CE activity:

Speaker Planner ___Activity Director Independent Reviewer (ICR)

A. DISCLOSURES

Have you (or your spouse/partner) had a relevant financial relationship with, and/or received or anticipate any form of remuneration from, in the last 12 months **with any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients?**
 Yes No If "YES", please list your disclosures:

<i>Check Relevant Boxes</i>	<i>Type of Financial Relationship (within the past 12 months) Include spousal/life partner relationships</i>	<i>Indicate Applicable Healthcare Manufacturers or Commercial Entities by Name</i>
<input type="checkbox"/>	Salary, Royalty, or Honoraria	
<input type="checkbox"/>	Receipt of Intellectual Property Rights / Patent Holder	
<input type="checkbox"/>	Consulting Fees (e.g., advisory boards)	
<input type="checkbox"/>	Speakers' Bureaus	
<input type="checkbox"/>	Supported/Contracted Research	
<input type="checkbox"/>	Ownership Interest (stocks, stock options, or other ownership interest <u>excluding diversified mutual funds</u>)	
Required by WUH Policy	Indicate the dollar amount of remuneration from the above relationships for the past 12 months.	\$

B. ATTESTATIONS/DECLARATIONS: Initial below to acknowledge/ agree to ALL items

___ As a planner, I will ensure that any speakers or content I suggest is independent of commercial bias.

___ As a planner, I will recuse myself from planning activity content in which I have a conflict of interest.

___ In my role as a planner or speaker at a Winthrop-accredited CME-CE activity, I agree to plan/ present only valid, balanced, independent, objective, and scientifically-based educational content that is free of commercial bias and influence. I agree to comply with all ACCME Standards of Commercial Support and all Federal requirements to protect health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I agree to resolve any relevant conflicts of interest that the CME Office identifies via this disclosure **prior** to the activity, and to comply with ACCME, ANCC and Winthrop CME-CE compliance policies.

___ As a speaker, I agree to disclose to learners any discussion of unapproved products or devices, or off-label use of FDA approved products or devices.

Signature _____ Date _____

Please return completed form to: Peter Sandre, Office of CME, 222 Station Plaza North, Suite 510 or via scan and email to peter.sandre@nyulangone.org

