UNIVERSITY of MARYLAND BALTIMORE

Continuing Education Activity
Biographical and Disclosure Form

Title of Educational Activity:

Educational Activity Date(s):

Role in Educational Activity: (Check all that apply)

- ☐ Planner/Activity Director
- ☐ Nurse Planner
- ☐ Faculty /Presenter/Author
- ☐ Moderator
- ☐ Content Expert
- ☐ Content Reviewer
- ☐ Other – Describe:

Section 1: Demographic Data

Name: **Degree(s):**

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

Phone Number: **Email Address:**

Current Employer and Position/Title:

Section 2: Expertise

Please briefly describe your expertise and experience specific to your role in this educational activity.

Section 3: Discussion of Healthcare Products

Will the CE content you control include discussion of off-label, experimental, and/or investigational use of drugs, devices, medical procedures, or interventions?

No ◯ (Skip to Section 4) Yes ◯ (Please complete questions below.)

Please list drugs, devices, and/or procedures to be discussed:

Faculty or authors who present off-label, experimental, and/or investigational uses of clinical interventions must initial here to attest that they will identify and disclose to the audience any discussion of unapproved products or procedures within their presentation.

Continue to Page 2. Once completed, save this form to your computer, and attach to the application form for your activity.

Section 4: Relevant Financial Relationships and Conflicts of Interest

In accordance with the Standards for Integrity and Independence in Accredited Continuing Education, as promulgated by ACCME, ACPE, and ANCC, everyone in a position to control the content of a CE activity is required to disclose to the accredited provider their ***relevant financial relationships***. *An individual has a relevant financial relationship if he or she has a financial relationship in any amount occurring in the last 24 months with an ineligible company whose products or services are discussed in the CE activity content over which the individual has control.* **Ineligible companies** are those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. Providers of clinical services directly to patients are NOT considered ineligible companies. The existence or non-existence of relevant financial relationships will be disclosed to the activity audience. All identified conflicts of interest must be resolved prior to the activity.

1. Have you had a financial relationship in any amount in the last 24 months with any ineligible companies (see definition above)? *Check Yes or No:*

   No ◯ (Skip to Section 5.)

   Yes ◯ (Please complete the chart below and respond to Question #2.)

For each financial relationship, enter the name of the ineligible company and the nature of the financial relationship(s). There is no minimum financial threshold; we ask that you disclose all financial relationships, regardless of the amount, with ineligible companies. You should disclose all financial relationships regardless of the potential relevance to the education.

Name of Ineligible Company	Nature of Relationship (e.g., employee, consultant, research grant recipient, speakers bureau, stockholder, etc.)	I have divested myself of this relationship.
		Yes ◯ **No** ◯
		Yes ◯ **No** ◯
		Yes ◯ **No** ◯
		Yes ◯ **No** ◯

2. Does the CE content over which you have control contain information about healthcare products or services of the ineligible companies you identified in the chart above?

   No ◯ Yes ◯

   If Yes, the Planning Committee will contact you regarding resolution of your conflict of interest.

Section 5: Statement of Understanding

The signature below serves as attestation that the information provided on this form is complete and accurate.

Please be advised that the any changes to the information stated on this form that occur between the date of submission and the activity date (e.g., any new financial relationships with an ineligible company) must be disclosed to the continuing education providers.

Typed or Electronic Signature **Date**

For Office Use Only:

COI Review/Date: Med ____/____ Nurs ____/____ Pharm ____/____ SW____/____