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| Biographical Sketch & Disclosure Form  For Education Program Speakers | | | http://www.iacrn.org/Resources/Pictures/image004.jpg | |
| Background Information | | | | |
| Name and credentials: | | | | |
| Preferred address:  City      , State       Zip | | | | |
| Preferred: Phone:       E-mail: | | | | |
| Employer and position (title): | | | | |
| **Educational preparation** (**DO NOT** ATTACH CURRICULUM VITAE)  *(Begin with baccalaureate or other initial professional education and include postdoctoral training.)* | | | | |
| Institution name and location (city, state) | Degree | Year of completion | | Field of Study |
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| Please provide a detailed description/list of your qualifications to present your topic, such as recent presentations, publications, pertinent work experience, training or education. | | | | |
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***Disclosure/Conflict of Interest Form for Presenters***

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| **Financial Disclosure/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** has a financial relationship with a *commercial interest*,\* the products or services of which are pertinent to the content of the educational activity. The Nurse Planner is responsible for evaluating the presence or absence of conflicts of interest and resolving any identified actual or potential conflicts of interest during the planning and implementation phases of an educational activity.  **\**Commercial interest***, as defined by 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. (Please reference content integrity document for further clarity <http://www.nursecredentialing.org/Accreditation-CEContentIntegrity.pdf> ) |

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| For the past 12 months, please indicate whether you or a member of your immediate family had a financial relationship in any amount with companies that produce, market, resell or distribute healthcare products or services that are used on or by patients (other than direct patient care). All information disclosed must be shared with the participants/learners prior to the start of the educational activity.    For each type of relationship, place a check mark in the appropriate column. If you were paid for your efforts, list the name of the entity providing support and the dates of the financial relationship. If you need to provide additional information about any of the relationships you list, please use the comment area at the bottom of this table. | |
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| **Type of Relationship** | **None** | **Financial relationship with you or family member** | **Entity Providing Support** | **Dates of relationship** |
| * Employment (full- or part-time employee, independent contractor) |  |  |  |  |
| * Consulting fee or honorarium |  |  |  |  |
| * Payment for lectures, including services on speakers bureaus |  |  |  |  |
| * Support for travel to meetings |  |  |  |  |
| * Research funding |  |  |  |  |
| * Fees for participation in advisory or review activities |  |  |  |  |
| * Provision of writing assistance, medicine, equipment, or administrative support |  |  |  |  |
| * Payment for development of educational materials, presentations or manuscripts |  |  |  |  |
| * Stock or stock options |  |  |  |  |
| Comments: | | | | |

**Please type your full name in the electronic signature box. This will act as your electronic signature for this form. If you hand sign the form, also print and/or type of name as indicated below.**

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| http://mc.manuscriptcentral.com/images/en_US/icons/check_mark_scoresheet.gif | To the best of my knowledge and belief, the information reported above is true and accurate. I understand that this information will be disclosed publicly at the educational program. I further understand that the program provider reserves the right to decline to allow me to present or otherwise limit my participation in this particular activity if they believe that a significant conflict of interest exists. I agree to notify the program provider if there is any change in the information that I have provided regarding my financial relationships prior to the presentation. |

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| Signature | Date signed |
|  |  |
| Printed Full Name |  |