AMERICAN ACADEMY OF PEDIATRICS (AAP) FULL DISCLOSURE STATEMENT FORM

As a provider accredited by the Accreditation Council for Continuing Medical Education (ACCME), the AAP is required to identify **and resolve** all potential conflicts of interest with any individual in a position to influence and/or control the content of CME activities. A conflict of interest will be considered to exist if the individual has received financial benefits in **any amount** from a commercial interest (any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients) within the past 12 months **and** that individual is in a position to affect the content of CME regarding the products or services of the commercial interest. All individuals in a position to influence and/or control the content of AAP directly and jointly provided CME activities are required to disclose to the AAP and subsequently to learners that the individual either has **no relevant financial relationships** or **any financial relationships** with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in CME activities. All disclosure information provided to the AAP will be reviewed to ensure that no conflicts of interest exist prior to the confirmation of the individual for the educational assignment. Additional information may be requested. **It is the responsibility of the individual to notify the AAP of any changes in the disclosure information provided after the submission of this *AAP Full Disclosure Statement Form.***

Name: ____ **Date:** _______________________________

Please check all that apply: ___ Faculty ___Author ___Planning Group/Committee ____Editorial Board ___AAP Committee on CME

____AAP Section/Council Program Chair ___Abstract reviewer ___Abstract presenter ___ Staff

Phone Number: _________________________**e-mail:** _____________________**Fax:** ____________________

Name of CME activity: _________________________________**Dates/location (if applies):** ___________________________

Clinical/Non-Clinical Topics: ____

Please complete Sections I and II; sign; date; and return this form to the appropriate AAP staff.

I. DISCLOSURE OF FINANCIAL RELATIONSHIPS WITHIN 12 MONTHS OF DATE OF THIS FORM

____ Neither I nor any member of my immediate family has a financial relationship or interest in any amount (currently or within the past 12 months) with any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.

OR

____ I have or ____an immediate family member has a financial relationship or interest in any amount (currently or within the past 12 months) with an entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients. The financial relationships are identified as follows (if needed, attach an additional list):

	Relevant Financial Relationships Related to Your Content (check all that apply)				
Name of Commercial Interest (any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.)	**Research Grant (including funding to an institution for contracted research)**	**Speakers' Bureau**	**Stock/Bonds (excluding Mutual Funds)**	**Consultant**	**Other (Identify)**

II. DISCLOSURE OF OFF-LABEL (UNAPPROVED)/INVESTIGATIONAL USES OF PRODUCTS

AAP CME faculty are required to disclose to the AAP and to learners when they plan to discuss or demonstrate pharmaceuticals and/or medical devices that are not approved by the FDA and/or medical or surgical procedures that involve an unapproved or "off-label" use of an approved device or pharmaceutical.

___ *I do intend* to discuss an unapproved/investigative use of a commercial product/device and will disclose such references to learners.

___ *I do not intend* to discuss an unapproved/investigative use of a commercial product/device.

I have read and will adhere to the *AAP Policy on Disclosure of Financial Relationships and Resolution of Conflicts of Interest for AAP CME Activities.* (If the policy is not attached to this form, email Taryn Daigle at taryn.daigle@laaap.org.) I understand that failure or refusal to disclose within the established timeframe will require the AAP to identify a replacement. I will uphold AAP Standards to insure balance, independence, objectivity and scientific rigor in my role in the planning or presentation of this CME activity.

Signature ____Date ____________________

RETURN BY __________________TO: Taryn Daigle at taryn.daigle@laaap.org