



Speaker Disclosure Report re: Potential Sources of Conflict of Interest

Name of Round (please circle one): Anesthesia | Cardiology | Emergency Medicine | General Surgery | Hospitalist | ICU/Critical Care | Infection/Pharmacotherapy | Medicine/Internal Medicine | Palliative Medicine | Pediatrics | Perinatal | Psychiatry | Quality & Safety | Research

Other: _____

Event Title/Topic:

Date of Event:

Please check any of the following that may apply in the past two years:

I have received direct financial support from a pharmaceutical or medical technology company to present at an educational activity.

No Yes

If yes company name(s):

I participate in clinical trials, studies, or research with a pharmaceutical company.

No Yes

If yes company name(s):

I have had real or have potential financial gain from the success of the product, information, or service presented at the planned education session (other than usual clinical or professional income).

No Yes

If yes provide details:

Other possible real or apparent conflict of interest:

Speaker Name: _____

(please print clearly)

Signature: _____

Speaker Contact Info (email/phone): _____

(optional)