

## Disclosure of Relevant Interests and HIPAA Compliance

The WVU School of Medicine is an accredited provider by the Accreditation Council for Continuing Medical Education (ACCME). The WVU School of Nursing is an approved provider of the State of WV Board of Examiners for Registered Professional Nurses. The WV School of Dentistry is an ADA CERP Recognized Provider. ACCME Standards for Commercial Support require that everyone in a position to control content of an educational activity must disclose all **relevant** financial relationships with any **Commercial Interest**. A **Commercial Interest is any entity producing, marketing, re-selling, or distributing healthcare goods or services consumed by, or used on, patients, with the exemption of non-profit or government organizations and non-health care related companies**. Any potential conflict(s) of interest that may exist as a result of a financial relationship will need to be resolved prior to the activity.

This information is necessary to continue planning this CE activity. Refusal to disclose **relevant** financial relationships will disqualify you from participating in this CE activity.

**CE Program Title:** \_\_\_\_\_

### Is this for:

- A Regularly Scheduled Series (ex. Grand Rounds, Weekly, Monthly)
- A conference
- A web course

**Name (REQUIRED):** \_\_\_\_\_  
*First Name, Middle Initial, Last Name*

**Profession:** \_\_\_\_\_  
*MD, DO, RN, etc.*

### Select your WVU/WVU Medicine affiliation (REQUIRED):

- None
- WVU Faculty (Full Time)
- WVU Faculty (Part Time)
- WVU Resident
- WVU Staff
- WVU Alumni

**Are you an employee or owner of an ACCME-defined commercial interest? (REQUIRED)** A Commercial Interest is any entity producing, marketing, re-selling, or distributing healthcare goods or services consumed by, or used on, patients, with the exemption of non-profit or government organizations and non-health care related companies.

- Yes
- No (*skip to Your Role section*)

### If yes, who is the Commercial Interest (REQUIRED)?

\_\_\_\_\_

The use of employees or owners of ACCME-defined commercial interests as faculty and planners or in other roles where they are in a position to control the content of accredited CME is prohibited, except in the specific situations specified here.

### Please choose the exception below that applies to you and your situation.

- The content of this CE activity is not related to the business lines or products of your employer.
- The content of the accredited CE activity is limited to basic science research (e.g., pre-clinical research, drug discovery) or the processes/methodologies of research, themselves unrelated to a specific disease or compound / drug. The content is not related to clinical applications of the research/discovery or clinical recommendations concerning the business lines or products of your employer.
- You are participating as technician to teach the safe and proper use of medical devices and will not include clinical recommendations concerning the business lines or products of your employer.
- None of these exceptions apply to my situation. Please explain: \_\_\_\_\_

### Your Role: Please indicate your role(s) in the planning and implementation of this CME program (REQUIRED):

- Speaker / Presenter
- Planning Committee Member
- Activity Director
- Activity Coordinator
- Content Reviewer
- CE Office Staff Member
- Joint Sponsor Representative

*Continued...*

**Attestations (ALL REQUIRED):**

- I will not accept payment for this activity from any outside commercial source, other than payments directly from the WVU Office of Continuing Education, its designated educational partner (non-commercial), or my employer.
- I will plan / present a program that is relevant to the participants' practices, commercially unbiased, objective, educationally balanced, and scientifically sound.
- I am in compliance with the HIPAA standards to protect the privacy of the patients, (if any), discussed in my presentation(s). I have either received written authorization from the patient, removed any identifiable images or patient records from my presentation, or my presentation does not pertain to patient treatment.
- I will provide references from scientific literature for all clinical recommendations (if any) in my presentation.
- The images presented in my presentation (if any) have not been falsified nor do they misrepresent the outcome of treatment.

**Disclosure of Relevant Relationships**

Determine if you or your spouse / partner have, or have had, a **relevant** financial relationship **within the past 24 months** with any Commercial Interests, as defined above. For this purpose, relevant financial relationships of your spouse or partner that you are aware of are considered to be yours. Complete **one** of the sections below:

**SECTION 1 - No Relevant Relationships to Disclose:**

If you determine that you or your spouse **DO NOT** have any relevant financial relationships as described above, please check the box, sign and date below and submit this form.

- Neither I, nor my spouse/partner, have relevant financial relationships with any Commercial Interests.

\_\_\_\_\_  
Signature (**REQUIRED**)

\_\_\_\_\_  
Date (**REQUIRED**)

**SECTION 2 - Relevant Relationships to Disclose:**

If you determine that you or your spouse **DO** have any relevant financial relationships as described above, please check the box, answer the questions, sign and date below and submit this form (**REQUIRED if relevant relationships exist**).

- Either I or my spouse have relevant financial relationships as described above.

**Please confirm that the information you will list below is RELEVANT to the presentation listed at the top of this form. You do not need to disclose relationships that are NOT relevant to the topic presented.**

- The information **IS RELEVANT**
- The information **IS NOT RELEVANT** (return to Section 1)

**Relationship 1:** Please indicate whether the relationship(s) are those of yourself or your spouse/partner:

- Me     My spouse/partner                      Has this relationship terminated:     Yes     No

Commercial Interest/Company Name: \_\_\_\_\_

What was received? \_\_\_\_\_                      What was your role? \_\_\_\_\_

**Relationship 2:** Please indicate whether the relationship(s) are those of yourself or your spouse/partner:

- Me     My spouse/partner                      Has this relationship terminated:     Yes     No

Commercial Interest/Company Name: \_\_\_\_\_

What was received? \_\_\_\_\_                      What was your role? \_\_\_\_\_

**Relationship 3:** Please indicate whether the relationship(s) are those of yourself or your spouse/partner:

- Me     My spouse/partner                      Has this relationship terminated:     Yes     No

Commercial Interest/Company Name: \_\_\_\_\_

What was received? \_\_\_\_\_                      What was your role? \_\_\_\_\_

*For additional relationships, please attach Commercial Interest Name, what was received and a description of your role.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**IMPORTANT:** One method of resolving potential conflicts of interest is to objectively determine that the program content is based on the best available evidence and represents a balanced view of therapeutic options. It must also promote improvements or quality in healthcare, NOT a specific proprietary business interest of a commercial interest. You will be asked to provide a copy of your content (power-point) in advance for review along with specific sources of evidence.