

**Full Disclosure for CME Activities**  
**American Family Physician authors**



Each author should complete the following disclosure statement:

<b>Author's Name:</b>
<b>Photo Quiz Title:</b>

**Disclosure of financial relationships within 36 months of the date of this form and within the foreseeable future**

**A.** Neither I nor any immediate family member (parent, sibling, spouse or child) has a financial relationship with or interest in any commercial entity that may have a direct interest in the subject matter of this article.

**B.** I have or an immediate family member (parent, sibling, spouse or child) has a financial relationship or interest with a commercial entity that may have a direct interest in the subject matter of this article. (Please check all the types of relationship that apply:)

- |   |   |
|---|---|
| <input type="checkbox"/> Consultant or Advisory Board<br><input type="checkbox"/> Employment<br><input type="checkbox"/> Honorarium<br><input type="checkbox"/> Manuscript Preparation Assistance<br><input type="checkbox"/> Other financial support (please list)<br><input type="checkbox"/> Ownership<br><input type="checkbox"/> Other personal or professional relationships (please list:)<br> | <input type="checkbox"/> Partnership<br><input type="checkbox"/> Receipt of equipment or supplies<br><input type="checkbox"/> Research Grants or support<br><input type="checkbox"/> Speakers' Bureaus<br><input type="checkbox"/> Stock/Bond Holdings (excluding mutual funds) |
|---|---|

If you checked statement B above, please indicate the names of the organizations with which you have financial relationships or interests, and the specific topic areas that correspond to each relationship. Use a separate piece of paper if you need more space.

Organization with Which Relationship Exists	Topic Area(s) Involved
1.	1.
2.	2.
3.	3.
4.	4.

If you checked "Speakers' Bureaus" under statement B, please check all of the following that apply:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Did you participate in company-provided speaker training?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Did you travel to participate in this training?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Did the company provide you with slides of a presentation in which you were trained as a speaker? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Did the company pay the travel/lodging/other expenses?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Did you receive an honorarium or consulting fee for participating in this training?               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you received any other type of compensation from the company? Please specify:                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you checked "Manuscript Preparation Assistance" under statement B, please answer the following questions:

- Was any assistance provided by a medical communications company or professional writer or editor?  Yes  No
- If so, who provided this assistance and who paid for it? \_\_\_\_\_

Please initial at the right and continue on the next page. Initials: \_\_\_\_\_

**Full Disclosure for CME Activities**  
**American Family Physician authors**

**Continued**

**All respondents**, please answer the following questions:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Did a pharmaceutical company, public relations firm or any commercial entity sponsor the substance or creation of your article directly or indirectly? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Was the topic of your article suggested by a medical communications company or a commercial entity producing health care goods or services?            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Was the topic of your article suggested by an advisory panel that receives support (for example, educational grants) from a commercial entity?         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Does your article incorporate, or is any part of it based on, slides or other materials provided by a commercial entity?                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Does your article incorporate information or data obtained from commercial speaker training?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Note:** Our conflict of interest policy precludes us from considering manuscripts sponsored directly or indirectly by a pharmaceutical company, medical education company, or other commercial entity, or those written by an author who has a financial relationship with or interest in any commercial entity that may have an interest in the subject matter of the article within the previous 36 months or in the foreseeable future. It also includes serving on a commercial speaker's bureau or advisory board, or receiving commercial research support related to the subject matter of the article, as well as other relationships detailed in our conflict of interest policy. If you develop new financial relationships with or interests in a relevant commercial entity after the time you completed this Author Disclosure form and submitted your manuscript, but prior to publication, please update your form and send it to our editorial office (see below). Changes in such affiliations might preclude your paper from publication.

I have read the AAFP policy on full disclosure (available online at <http://www.aafp.org/journals/forms/coipolicy.pdf>). If I have indicated a financial relationship or interest, I understand that this information will be reviewed to determine whether this relationship precludes my participation, and that I may be asked to provide additional information. I understand that failure or refusal to disclose, false disclosure, or inability to resolve conflicts of interest will disqualify me from participating in this activity. I represent and warrant that the information provided by me in this form is complete, true and accurate.

Signature \_\_\_\_\_

Date: \_\_\_\_\_

**Please fax, e-mail, or mail completed form(s) to Photo Quiz coordinator,  
American Family Physician, 11400 Tomahawk Creek Parkway, Leawood, KS, 66211.  
Fax: 913-906-6086      Email: [afpphoto@aafp.org](mailto:afpphoto@aafp.org)**

10/2012