AANP CE Faculty Biographical Sketch Form with Preliminary Disclosure

****Submit a brief bio-sketch (2-page limit) for each presenter/faculty person. CV or resume will NOT be accepted. This form will be used to ensure faculty educational preparation and experience in the related content area.**

Name: _____ Degrees: _____

Address: _____

Telephone: _____

Present Employer: _____

Current Title: _____ Current Position Description: _____

EDUCATIONAL BACKGROUND:

Degree	Institution (Name, City, State	Major Area of Study	Year Completed

BRIEFLY SUMMARIZE PROFESSIONAL EXPERIENCE/EXPERTISE RELATED TO TOPIC:

_____

_____

_____

Will the content of your material(s)/presentation(s) in the CE activity include discussion of unapproved or investigational uses of products or devices? ☐ No ☐ Yes (specify all off-label or investigational use):

_____

_____

PRELIMINARY DISCLOSURE OF FINANCIAL RELATIONSHIPS

Within 12 months of the date of this form, have you or an immediate family member had any of the following financial relationship or other affiliation with a proprietary entity producing health care goods or services?

Examples include research grants, speakers bureaus, ownership, consultant for fee, stock/bond holdings (excluding mutual funds), employment, and partnership.

☐ No (no further disclosure required) ☐ Yes (must complete full ***Faculty Disclosure Form***)

Signature: _____ Date: _____

(Electronic Signature accepted: Typed name with date indicates electronic verification of the information provided).

AANP Continuing Education Faculty Disclosure Form

Name:

_____

____

Contact Phone: _____ Contact E-mail:

_____

Presentation Title:

_____

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

I have or an immediate family member has a financial relationship or other affiliation with a proprietary entity producing health care goods or services. Please check all that apply to the relationship(s).

- ☐ Research Grants
- ☐ Speakers Bureaus*** (see * below)**
- ☐ Ownership
- ☐ Consultant for Fee
- ☐ Stock/Bond Holdings (excluding mutual funds)
- ☐ Employment
- ☐ Partnership
- ☐ Other (please list) _____

Please indicate the names of the organizations with which you have a financial relationship or interest, and the specific clinical areas that correspond to the relationship. If more than four relationships please list on separate page:

Company with which Relationship Exists	Clinical Area/Disease State Involved
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**

*__Speakers Bureau members ONLY__ complete this section

Did you participate in company-provided speaker training related to your proposed topic?	____ Yes	____ No
Did the company provide you with slides of the presentation in which you were trained as a speaker?	____ Yes	____ No
Did the company pay the travel/lodging/other expenses?	____ Yes	____ No
Did you receive an honorarium or consulting fee for participating in this training?	____ Yes	____ No
When serving as faculty for the CE Provider, will you use slides provided by a proprietary entity for your presentation/handout materials?	____ Yes	____ No
Will your topic involve information or data obtained from commercial speaker training?	____ Yes	____ No

DISCLOSURE OF UNLABELED/INVESTIGATIONAL USES OF PRODUCTS

(This **section** MUST be completed).

- ☐ The content of my material(s)/presentation(s) in the CE activity **will not** include discussion of unapproved or investigational uses of products or devices.
- ☐ The content of my material(s)/presentation(s) in the CE activity **will** include discussion of unapproved or investigational uses of products or devices. **Verbal disclosure will be made during the presentation.**

Please specify off-label or investigational use:

_____

_____

_____

If I have indicated a financial relationship or interest, I understand that this information will be reviewed to determine whether a conflict of interest may exist, and I may be asked to provide additional information. I understand that failure to disclose, false disclosure, or inability to resolve conflicts of interest will require the CE Provider to identify a replacement.

Signature: _____Date: _____

(Electronic Signature accepted: Typed name with date indicates electronic verification of the information provided).

AANP Policy: Programs with faculty serving on an industry speakers bureau in related clinical areas will be considered, providing that peer review or another approved method of conflict resolution is completed and details submitted prior to the activity's accreditation. Peer review of program slides is required for activities covering the same clinical area as a faculty member's speakers bureau activities, when content includes therapeutic options beyond incidental mention of broad classes of drugs.