LOUISIANA ACADEMY of FAMILY PHYSICIANS

CME DISCLOSURE FOR CONFLICTS OF INTEREST FORM

Name:	**Email Address:**
Address:	
City/State/Zip:	
Office Phone:	**Cell Phone:**
Presentation Title:	**Date/Time of Presentation:**
Role you hold specific to this CME activity: ☐ LAFP Physician Leadership ☐ Presentation Faculty ☐ Education Committee Member ☐ CME Company Organizer	
Tax ID # or Social Security # ☐ N/A	Date of Birth: ☐ N/A

Full Disclosure for CME Activities

All individuals in a position to control content must disclosure online to the LAFP any financial relationships they or their spouse or domestic partner have had with ineligible companies within the previous 24 months (36 months for journal editors and editorial board members) or might have within the foreseeable future. *An ineligible company is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. Individuals must disclose all financial relationships with ineligible companies, regardless of the amount or the potential relevance to the education.*

☐ A. In the past 24 months (36 months for journal editors and editorial board members), I have not had a financial relationship with an ineligible company.

☐ B. In the past 24 months (36 months for journal editors and editorial board members), I have had a financial relationship with an ineligible company. Check all that apply:

☐ Research Grants ☐ Consultant or Advisory Board ☐ Employment
☐ Speakers' Bureau** ☐ Consultant for Fee ☐ Partnership
☐ Ownership ☐ Manuscript Preparation ** ☐ Honorarium
☐ Receipt of Equipment or Supplies ☐ Stock/Bond Holdings (excluding mutual funds)
☐ Other (Please List) _____

Please indicate the names and organization(s) with which you have a financial relationship or interest, the type of relationship, and the topic area that correspond to the relationship. If more than four relationships, please list on a separate piece of paper.

Organization with which Relationship Exists	Type of Relationship	Topic Area(s) Involved
1.		
2.		
3.		
4.		

*** If you checked "Speakers' Bureau" in Item B, please continue:*

1. Did you participate in company provided- speaker training related to your topic? ☐ Yes ☐ No
2. Did you travel to participate in this training? ☐ Yes ☐ No
3. Did the company provide you with any slides or the presentation in which you were trained as a speaker? ☐ Yes ☐ No
4. Did the company pay the travel/lodging/other expenses? ☐ Yes ☐ No
5. Did you receive an honorarium or consulting fee for participating in this training? ☐ Yes ☐ No
6. Have you received any other type of compensation from this company? If yes, please specify: ☐ Yes ☐ No

_____

7. When serving as faculty for the LAFP, will you use slides provided by a proprietary entity? ☐ Yes ☐ No
8. Will your topic involve information or data obtained from commercial speaker training? ☐ Yes ☐ No

*** If you checked "Manuscript Preparation" in Item B, please continue:*

1. Was any assistance provided by a commercial interest, medical communications company, or professional writer? ☐ Yes ☐ No

   If yes, please describe who provided the assistance: _____

_____

2. Was this topic suggested by an advisory panel that receives support (ex: educational grant) from a commercial interest? ☐ Yes ☐ No

DISCLOSURE OF UNLABELED/INVESTIGATIONAL USES OF PRODUCTS

☐ A. The content of my material(s) / presentation(s) in this CME activity **WILL NOT** include discussion of unapproved or investigational uses of products or devices.

☐ B. The content of my material(s) / presentation(s) in this CME activity **WILL include** discussion of unapproved or investigational uses of products or devices.

☐ I have read and understand the LAFP policy on full disclosure. If I have indicated a financial relationship, I understand that this information will be reviewed to determine whether this relationship precludes my participation, and I may be asked to provide additional information. I understand that it is necessary to notify relevant staff and update disclosure information should my status change during the course of the CME activity. I understand that failure or refusal to disclose, false disclosure, or inability to resolve any relevant financial relationships will disqualify me from participating in this activity.

Signature: _____ Date: _____

Please upload this form with your CME Faculty Proposal Application or return the form by January 30, 2026 to:

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