**International Association for Human Caring**

**Financial Disclosure Form**

IAHC Annual Conference Date: June 3-September 3, 2023.

Title of Offering \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Abstract Submission Number \_\_\_\_\_\_\_\_\_\_

 IAHC Nurse Planner

 Content Expert

Planning Committee Member

 Content Reviewer

 Faculty/Presenter/Author

Name, Degrees & Credentials

If RN, nursing degrees(s): AD Diploma BSN Masters PhD/DNP

Day Telephone:     Email Address:

Present Position (Title) \* Employer:

 Describe your familiarity with the target audience:

**Financial Disclosure Statement**

Please disclose all financial relationships that you have had in the **past 24 months** with **ineligible companies. An ineligible company is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.**

For each financial relationship, enter the name of the ineligible company and the nature of the financial relationship(s). There is **no minimum financial threshold**; we ask that you disclose all financial relationships, regardless of the amount, with ineligible companies. You should disclose **all financial relationships regardless of the potential relevance** of each relationship to the education.

|  |  |  |
| --- | --- | --- |
| **Enter the Name of Ineligible Company**An **ineligible company** is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.For specific examples of ineligible companies visit [www.accme.org/standards](http://www.accme.org/standards) | **Enter the Nature of Financial Relationship** Examples include employee, researcher, consultant, advisor, speaker, independent contractor (including contracted research), royalties or patent beneficiary, executive role, and ownership interest). Individual stocks and stock options **MUST** be disclosed; diversified mutual funds do not need to be disclosed. Research funding from ineligible companies **MUST** be disclosed by the principal or named investigator even if that individual’s institution receives the research grant and manages the funds. | **Has the Relationship Ended?**If the financial relationship existed during the last 24 months, but has now ended, please check the box in this column. This will help the education staff determine if any mitigation steps need to be taken. |
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|  **In the past 24 months, I have not had any financial relationships with any ineligible companies.** |
| **I attest that the above information is correct as of this date of submission. DATE:**  |

 **There are three exceptions that allow for owners and/or employees of ineligible companies to participate as planners or faculty in nursing continuing professional development activities that award contact hours:**

1. When the content of the activity is not related to the business lines or products of their employer/company.

2. When the content of the activity is limited to basic science research, such as pre-clinical research and drug discovery, or the methodologies of research, and they do not make care recommendations.

3. When they are participating as technicians to teach the safe and proper use of medical devices, and do not recommend whether or when a device is used.

As the presenter whose signature appears below, I have disclosed any financial relationships or have met or more of the exceptions listed above. I agree to present any information that might represent a potential conflict of interest fairly and without bias.

Signature and Credentials:\_\_\_\_\_\_\_\_\_ Date:

 **By checking this box, I am providing my electronic signature approving all the information entered above. (Please enter name, credentials and date on signature and date lines above).**

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**Information below to be completed by IAHC Nurse Planner.**

**Has this person disclosed any financial relationship and if there is a financial disclosure, do they meet one or more of these exceptions?**

**YES ☐**

**NO ☐**

**NA ☐**

**If yes**, complete the following ***Exception Table***:

|  |  |  |  |
| --- | --- | --- | --- |
| **Individual’s Name** | **Ineligible Company** | **Exception****(from list of 3)** | **Role in this NCPD Activity** |
|  |  |  |  |
|  |  |  |  |

IAHC Nurse Planner Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_