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| **DISCLOSURE OF CONFLICT OF INTEREST****9th International Research Conference on FASD***March 20 – 23, 2025*The Hyatt Regency, Seattle, WA, USA FASD United is dedicated to ensuring that all participants of programs offered by FASD United are notified of potential conflict of interest. A conflict of interest is defined as a situation where the personal and professional interests of individuals may have actual, potential or apparent influence over their judgment and actions. Please check the statement that applies to you:🞎 I do not have an affiliation (financial or otherwise) with a pharmaceutical, medical device or communications organization. Speakers who have no involvement with industry should inform the audience that they cannot identify any conflict of interest.🞎 I have/had an affiliation (financial or otherwise) with a pharmaceutical, medical device or communications organization. Complete the table below as it applies to you during the past two calendar years. Please indicate the commercial organization(s) with which you have/had affiliations, and briefly explain what connection you have/had with the organization. **You must disclose this information to your audience.**

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|  | Company/Organization | Details |
| Ownership interest in the company or membership on the company’s advisory board or similar committee(s) (Excluding diversified mutual funds). |  |  |
| Involvement in research sponsored by the company or participation in clinical studies concerting the use of the products manufactured by the company. |  |  |
| Monetary support received from or expected from the company (honorarium, consulting fees, salary, royalty, grand, etc). |  |  |
| Ownership of a patent for a product referred to in the presentation or marketed by the company. |  |  |
| Other financial ties that should be declared. |  |  |

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|  | Yes | No | You must declare all off-label use to the audience during your presentation |
| I intend to make therapeutic recommendations for medications that have not received regulatory approval (i.e. “off-label” use of medications). |  |  |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that the above information is accurate. (name)Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please complete and return by **February 26** to votolato@fasdunited.org.