

10th International Conference on
**Adolescents and Adults with
 Fetal Alcohol Spectrum Disorders**
 Integrating Research, Practice, and Policy Around the World



April 18 - 21, 2026 **The Hyatt Regency, Seattle, WA**

DISCLOSURE OF CONFLICT OF INTEREST

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.**

	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 concerning 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.		

	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 March 16 to [Dropbox](#).