

**Westchester Academy of Medicine**

Office of Continuing Medical Education

333 Westchester Ave., Suite LN01 Telephone: 914-967-9100

# White Plains, NY 10604

**Activity Name: Activity Date:**

# Disclosure Attestation By Program Director

**Provider Representative:**

All those with the potential to control the content of the CME activity (planners, presenters, moderators, authors etc.) are expected to disclose to the audience:

A. Any significant financial interest or other relationship with the provider of commercial products or services discussed in their educational presentation. The nature of the relationship must be disclosed.

*And/or*

1. Any significant financial interest or other relationship with the provider of commercial products or services that have directly supported the CME activity through an educational grant to the sponsoring organization(s).

* Disclosure must be documented on the Disclosure of Relevant Financial Relationships Form
* Disclosure must take place prior to the actual presentation
* Disclosure must be published in the brochure, syllabus or other handouts
* Disclosure can be accomplished verbally by either the activity chair or faculty member
* Disclosure can be accomplished in written form distributed to each learner

A representative of the provider will be responsible for compliance with the Disclosure Policy.

**\_\_\_Yes \_\_\_No The signed disclosure form(s) from everyone with the potential to control the content of the CME activity describing the nature of the relevant financial relationship(s) are attached**.

If No, why not?

Disclosure was made to the audience prior to the start of the activity in the following format(s): written\_\_\_\_\_ verbal\_\_\_\_\_ both\_\_\_\_\_

**The following disclosures were made to the learners prior to the start of the CME activity:**

(Provide a list of the exact relevant financial relationship disclosed to the learners, including that there were no relevant financial relationship to disclose).

Verified by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(must be submitted within one month of activity date)