

SPEAKER REQUIREMENTS

Your signature at the bottom of this form will indicate that you agree to comply with each statement listed below.

I will disclose to the ACP any relevant financial interest or relationship that I have with a commercial company or the manufacturer(s) of any commercial product/service that may influence my presentation(s).
I understand that the Program Committee members will review my disclosure form and may require that perceived conflicts be resolved prior to my presentation(s). This could include the review of my presentation(s) and/or content prior to the activity.
I will verbally disclose to the audience any relevant conflicts of interest at the onset of my presentation(s) and will include a disclosure slide at the start of my presentation(s).
I agree to advise the audience if my presentation includes any discussion of a product not labeled by the FDA for the use under discussion or that is still investigational.
I agree to design a presentation that is free from commercial bias for or against any product and will promote quality or improvements in healthcare and will not promote a specific proprietary business interest or a commercial interest.
I agree to give a balanced view of therapeutic options by using generic names to the extent possible when discussing specific health care products or services. If discussing trade names, I will use trade names from several companies when available, and not just trade names from any single company.
I will support my presentation and clinical recommendations with the “best available evidence” from current medical literature. All scientific research referred to, reported or used in support or justification of patient care recommendations will conform to the generally accepted standards of experimental design, data collection and analysis.
I understand that a formal observer may be attending the event to ensure that my presentation is educational, and not promotional, in nature.
I agree not to accept any honoraria, additional payments or reimbursements for this CME activity beyond what has been agreed upon directly with the ACP.

Name: (Please print) _____

Signature: _____

Date: _____

**PLEASE RETURN THIS COMPLETED FORM
VIA FAX TO 510-346-6808 NO LATER THAN AUGUST 15, 2008.**