

The Division of Pharmacy Professional Development
School of Pharmacy, University of Wisconsin
777 Highland Avenue, Madison, WI 53705

DISCLOSURE DECLARATION FOR CE PROGRAM FACULTY/PROVIDERS/PLANNING COMMITTEE

The Division of Pharmacy Professional Development (DPPD) at the University of Wisconsin-Madison School of Pharmacy is accredited by the Accreditation Council for Pharmacy Education (ACPE) as a provider of pharmacy continuing education. Consistent with accreditation standards and our own internal policies, our goal is to insure balance, independence, objectivity, and scientific rigor in all educational programs for which we serve in a sponsorship/provider role. Thus, anyone who is in a position to control the content of an educational activity must disclose to DPPD all relevant financial relationships with any commercial interest. Disclosures will be reviewed by DPPD. Should it be determined that a conflict of interest might exist as a result of a reported financial interest, this will need to be resolved prior to the activity through a follow-up communication to be initiated by DPPD. Further, presenters are required to identify if they will address off-label use of any drugs/devices. The intent of these disclosure policies is not to prevent an individual from contributing to the content of a program; rather, the intent is to allow DPPD to openly identify and resolve factors which may impact program content and, in turn, allow program participants to form their own judgements about the program.

TERMS AND CONDITIONS

By completing/signing page 2 of this document, the faculty member/provider understands and accepts the following conditions as defined and required by the Division of Pharmacy Professional Development (DPPD):

1. **Disclosure.** A Disclosure Declaration must be completed/submitted not later than 45 days prior to the educational activity. Refusal to submit a Disclosure Declaration will result in disqualification from participation in the program.
2. **Commercial Interest.** Any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients. This includes all commercial interests, not just those that might be directly related to the specific program for which a disclosure is signed. Providers of clinical service directly to patients are not commercial interests.
3. **Relevant Financial Relationship.** Financial relationship of any amount occurring within the past 12 months that create a conflict of interest; this includes relevant financial relationships of a spouse or partner.
4. **Fair-Balance.** Presentations must be fair-and-balanced, e.g., objective, free from promotion of a product, device and/or service, and scientifically rigorous.
5. **Unlabeled and Unapproved Uses.** Presenters who provide information in whole or in part related to non-FDA approved uses for drug products and/or devices must clearly acknowledge the unlabeled indications or the investigative nature of the proposed use(s) to the audience. Presenters who plan to discuss non-FDA approved uses for commercial products and/or devices must advise DPPD of their intent by indicating such on the signed disclosure form.
6. **Use of Generic versus Trade Names.** Presenters should use scientific or generic names in referring to products in their lectures or enduring materials. Should it be necessary to use a trade name, then the trade names of all similar products or those within a class should be used.
7. **Commercial Supporter Influence.** Presenters should not be subject to influence from a commercial entity regarding the content of their presentation.
8. **Faculty Honorarium.** A faculty honorarium will be paid only upon successful delivery/completion of the program. Payment of honorarium/expenses to faculty will be made directly by the provider or an educational partner approved by the provider.

DISCLOSURE DECLARATION FOR CE PROGRAM FACULTY/CONTENT CONTRIBUTORS/PLANNING COMMITTEE
(Note: except for signature, please print for clarity)

TITLE OF CE ACTIVITY/PRESENTATION: Engage-IL Project

PROGRAM DATE: Home Study: Release Date 7-1-2016

NAME: First GURVEEN Middle Initial P Last MALHOTRA

Home Address 1027 S OAKLEY BLVD, APT-2

City CHICAGO **State** IL **Zip** 60612

Signature _____ Gurveen _____ **Date** 5/13/2016

A response to #1, #2 and #3 is required.

- I, or a spouse/partner, have a financial relationship with a commercial entity (Note: definitions of financial relationship and commercial interest are found on page 1 of this document. Further, this includes all commercial entities, not just those which might have a specific relationship to this program.)

No Yes (If yes, please provide details below in a printed, legible manner)

Commercial Interest (e.g., name of company)	Nature of what I received (not \$ amount; e.g., salary, consulting fee, honoraria, stock benefits, grant, etc.)	My role (speaker, advisory board, review panel, research, consulting, etc.)

- I agree to the "Terms and Conditions" listed on page 1 of this form.

No Yes

- I intend to reference unlabeled/unapproved uses of drugs or products in my presentation.

No Yes Not Applicable

If Yes, please specify product name/use:

Product Name(s) _____

Therapeutic Use(s) _____

PLEASE RETURN BY EMAIL OR FAX TO: Ruth Bruskiewitz, ruth.bruskiewitz@wisc.edu FAX 608-262-2431