

# Faculty and Planner Agreement for a CME Activity

Title of Activity:  Starting Date for Activity: Your Name and Degree (s):  Institutional Affiliation: Your Role in Activity:  Planner  Presenter/Author  Activity Director  Moderator  Reviewer  Staff Medical Expert  
(check all that apply)

**DIRECTIONS:** Read the ACCME Content Validity Values Statement below, then **read and check ALL** of the following boxes to attest to your understanding of and willingness to comply with the corresponding statement; accept terms and date form.

**ACCME Content Validity Values Statement:** All recommendations involving clinical medicine in a CME activity must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contra-indications in the care of patients. All scientific research referred to, reported or used in CME in support or justification of a patient care recommendation must conform to the generally accepted standards of experimental design, data collection and analysis.

**Best Available Evidence and ACCME Content Validation Statement:** All clinical recommendations that I make for patient care as part of my planning and/or CME activity materials will be based on the best available evidence and the content will be in compliance with ACCME's Content Validation Statement.

**Sources and Limitations of Data, Off-Label Use Disclosure:** To the extent practical, recommendations involving clinical medicine in this CME activity will be substantiated by peer-reviewed sources. I will make meaningful disclosure to the attendees if products or procedures I discuss are off-label, unlabeled, experimental, and/or investigational (not FDA approved), and any limitations on the information that I present, such as data that are preliminary or that represent ongoing research, interim analyses, and/or unsupported opinion.

**Scientific Integrity:** All scientific research referred to, reported or used in support or justification of a patient care recommendation will conform to generally accepted standards of experimental design, data collection and analysis.

**Free of Commercial Bias:** CME content presented to learners will be free of commercial bias. No product, service, or therapeutic option will be over-represented when comparing competing products, services, and therapeutic options. When appropriate, generic names or trade names from several companies will be used.

**Payments:** I have not and will not accept an honorarium, additional payment, or reimbursements except for payments from the CME provider or authorized representative for my participation in this activity. I understand that all payments to me will be made in compliance with the provider's Policy on Honoraria and Expense Reimbursement.

**Serve the Public Interest:** Any selection of topics, instructional content and personnel I make for this CME activity will be done to serve the public interest by improving the quality of healthcare. To the best of my ability, I will not let any personal financial relationships influence this selection process.

**Presentations must give a balanced view of therapeutic options:** Use of generic names will contribute to this impartiality. If your presentation includes trade names, where available trade names from several companies should be used, not just trade names from a single company. Logos from commercial interests are never permitted on any course materials including presentation slides. Your presentation/materials will be evaluated by attendees for fair balance, objectivity and scientific rigor.

**Content Validation Review:** I understand that my CME activity presentation/materials may be prospectively peer-reviewed for fair balance and validation of content and may require editing.

**HIPAA Compliance:** I will remove all patient identifiers (name, birth date, address, phone number, medical record number, account number, social security number, etc.) from my presentation materials. I will not use identifiable photographs of patients, unless I have obtained written patient permission.

By clicking this circle, I attest that I have agreed to the above statements. Date of Submission:

**To return this completed form to the Medical Society of Delaware, click on the 'E-mail Form' button to the right, which will automatically attach it to a pre-addressed e-mail. Be sure to save a copy for your files by clicking on the 'Print Form' button to the right.**