**Doctors of Nursing Practice 10thNational Conference, New Orleans, LA, Sept 13-15, 2017**

**Biographical Data and Conflict of Interest Form**

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| --- | --- | --- | --- |
| My role in this continuing education activity is as a (check all that apply):        Nurse Planner\* Content Expert       Planning Committee Member  Faculty/Presenter/Author       Content Reviewer       Other (Describe ) | | | |
| Name, Degrees & Credentials: |  | | |
| If an RN, Highest Nursing Degree: AD, Diploma, BSN, Masters, Doctorate |  | | |
| Home Address or Business Address |  | | |
| City, State and Zip Code |  | | |
| Day Telephone: Email Address: |  | Fax Number: |  |
| Email Address: |  | | |
| Present Position (Title) & Employer: |  | | |
| Describe professional experience or areas of expertise, which contribute to involvement. This might include your educational background, publications or experience. **Please do not attach resumes or CVs.**  \*NOTE: If you are the nurse planner, you must provide information about your expertise/education in adult education or adult learning and ANCC criteria. |  | | |

**Conflict of Interest Disclosure Statement**

**The potential for conflict of interest exists when an individual has the ability to control or influence the CE content (either through planning, implementation or reviewing) and they have a financial relationship with a *commercial interest, the* products or services of which are pertinent to the content of the educational activity.**

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| --- | --- | --- | --- | --- | --- |
| **Do you have an actual or perceived conflict of interest for yourself or your spouse partner?** | | | | Yes | No |
| If yes, describe potential conflict(s) of interest below: | | | | | |
| Salary | |  | | | |
| Honorarium | |  | | | |
| Royalty | |  | | | |
| Stock | |  | | | |
| Speaker’s Bureau | |  | | | |
| Consultant | |  | | | |
| Other | |  | | | |
| How will this potential conflict(s) of interest be resolved prior to the activity? (Check all that apply)  *All conflicts of interest MUST be resolved with the Nurse Planner PRIOR TO the implementation of the activity.* | | | | | |
|  | | I have discussed conflict with Nurse Planner and agree to the Conflict of Interest policy. | | | |
|  | | I have signed a statement that says I will present information fairly and without bias. | | | |
|  | | The Nurse Planner or designee will monitor the session/content to ensure no conflict of interest arises. | | | |
|  | | Other (describe): | | | |
| Will you be discussing any off label uses of therapeutic interventions? | | | | Yes | No |
| If yes, how will you disclose this information? | | |  | | |
|  | By checking this box, I am providing my electronic signature affirming that all the information entered above is accurate and complete**.**  I have identified and resolved in writing all potential conflicts of interests. As a planning committee member or presenter, I am resolving my conflict **of** interest by agreeing that I will not allow any conflict of interest or commercial support to bias my participation in this activity. | | | | |
| Date |  | | | | |

**Nurse Planner Attestation**

|  |  |
| --- | --- |
|  | By checking this box, I am providing my electronic signature affirming that all the information entered above is accurate and complete. I have identified and resolved in writing all potential conflicts of interests. As a planning committee member or presenter, I am resolving my conflict of interest by agreeing that I will not allow any conflict of interest or commercial support to bias my participation in this activity. |
| Date | *Nurse Planner signs here (the Nurse Planner 's BIO/COI must be signed by another committee member)* |