



## 2020 Minnesota Orthopaedic Society's Annual Meeting Abstract Proposal

### Section 1: Presentation Information

**Please note that the person presenting the abstract will need to complete a Continuing Medical Education disclosure form which is at the end of the abstract submission.**

\* 1. Abstract title:

\* 2. Presenting Author Name (Please include designations. This information will be printed in the onsite packets.)

\* 3. Co-author (s) (Please include designations)

\* 4. Background

\* 5. Methods

\* 6. Results

\* 7. Conclusions



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Section 2: Speaker Information

\* 8. Primary Contact and First Speaker

First Name:

Last Name:

Designation:

Title/Position:

Employer:

E-mail Address:

\* 9. PRESENTER'S BIOGRAPHY 100-200 words; please provide in paragraph/narrative format.



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**Innovative Continuing Education, LLC Disclosure Form: Minnesota Orthopaedic Society**

**Organization: Minnesota Orthopaedic Society (MOS)**

**Event: MOS' Annual Meeting**

**Date: 5/8/20**

**Questions Contact: Rosemary at [Office@mnorthopaedic.org](mailto:Office@mnorthopaedic.org) or (952) 929-9398**

Purpose: It is the policy of Innovative Continuing Education, LLC (ICE), in accordance with the Accreditation Council for Continuing Medical Education (ACCME), to ensure balance, independence, objectivity, and scientific rigor in all CME activities. Anyone engaged in content development, planning or presentation must complete this form. Disclosure information is reviewed in advance in order to manage and resolve any possible conflicts of interest. Specific disclosure information for each speaker, course director, and planning committee member will be shared with the audience prior to the speaker's presentation.

10. General Information

Name:

Presentation Title:

Type of Presentation  
( Podium, Abstract, E-  
Abstract, Other):

11. Role: Check all that Apply

- Presenter
- Author
- Course Director
- Moderator
- Planning/ Approval Committee
- Comment

**Disclosure of Relevant Financial Relationships:** Relevant financial relationships are those in which an individual (including the individual's spouse/partner) in the last 12 months: 1) has had a personal financial (any amount) relationship with a commercial interest\* producing health care goods or services; and who 2) also has the opportunity to affect the content of CME activity about the products or services of that commercial interest.

\*A commercial interest is any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.

If a planner, faculty, course director or author refuses to complete the disclosure he/she will not be able to participate.

\* 12. Regarding Your Role In This Activity

- No, I have no relevant personal financial relationship. skip to question 19
- Yes, I do have a personal financial relationship. (provide necessary information to questions 13-19).

## Nature of Financial Relationship

13. Consultant

- Yourself
- Spouse/Partner

Name of Company (S)

14. Honoraria Received

- Yourself
- Spouse/Partner

Name of Company (S)

15. Speaker's Bureau Participation

- Yourself
- Spouse/Partner

Name of Company (S)

16. Grant/Research Support (Principal Investigator or working directly for company/company's agent)

- Yourself
- Spouse/Partner

Name of Company (S)

17. Stock Shareholder (Self Managed)

- Yourself
- Spouse/Partner

Name of Company (S)

18. Other, e.g., royalty, employee (Describe)

- Yourself
- Spouse/Partner

Name of Company (S)

\* 19. Disclosure of Promotional Talks.

Have you presented any promotional talks for any commercial interest within the past 12 months?

- No. (Skip to question 20)
- Yes. (Please provide the following information).
- If yes, Please name company (s), Therapeutic Area and Month/Year Presented

**Declaration:** I will uphold Innovative Continuing Education, LLC's continuing educational standards to ensure balance, independence, objectivity, and scientific rigor in my role in the planning, development or presentation of this CME activity. Any recommendations are based on the best available evidence or are consistent with generally accepted medical practice. I understand that continuing education accreditation guidelines prohibit me from accepting any reimbursement (financial, gifts, or in-kind exchange) for this presentation from any source other than the accredited CME provider or its educational partner (or fiscal agent).

By submitting this form electronically, I attest that the completed information is accurate. Please accept this as my signature.

20. Signature

Name:

Email:

Date: