FACULTY DISCLOSURE FORM
Conflict of Interest

Office of Continuing Medical Education
University of Virginia School of Medicine

Name: Suzanne Koren MD
Title of CME Activity: Medical Grand Rounds
Date(s) of CME Activity: 10/11/19
Sponsoring Department (UVA) or Affiliate Organization:

Role in CME Activity:
☐ Course Director
☐ Planning Committee
☒ Speaker/Author

1. Disclosure of financial relationship(s):

☐ I (and/or my spouse/partner) have a personal or professional financial relationship with a commercial entity producing healthcare goods and/or services.

If you (and/or your spouse/partner) have a financial relationship(s):

A. Please indicate the names of the commercial organizations and the clinical/research areas where you have a financial relationship(s). If you have more than 4 relationships, please add additional pages.

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>Clinical/Research Area</th>
<th>Type of Financial Relationship (Use Code Below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Employment (includes retainer)  e. Advisory Committee/Board
b. Industry funded research/investigator  f. Stock/Ownership
c. Consultant  g. Patent holder
d. Speakers Bureau, Faculty, Peer Reviewer  h. Other (please describe)

OR
I (and/or my spouse/partner) do not have a personal or professional financial relationship or interest with any proprietary entity producing healthcare goods or services.

2. Attestations (Please respond to all statements):

A. I understand that my responsibility as a faculty presenter/author/editor/planner is to develop and provide the content and/or presentation that focus on the improvement of health care for patients.
   - [☑] Agree       - [☐] Disagree

B. I will not promote any specific proprietary or commercial business interest as part of my role in the planning and delivery of this CME certified activity. Content for this activity will provide a well-balanced, evidence-based and unbiased approach to diagnostic and therapeutic options related to quality patient care.
   - [☑] Agree       - [☐] Disagree

C. I will provide the educational content and resources for independent peer review as requested by the UVA Office of Continuing Medical Education.
   - [☑] Agree       - [☐] Disagree

D. I will identify to participants any discussion of non-FDA approved or investigational uses of products or medical devices included in my presentation/article/case/discussion.
   - [☑] Agree       - [☐] Disagree

I have carefully considered each item and have answered all of these attestations to the best of my knowledge. (If sending electronically, your email copy will serve as your signature.)

[Signature] ___________________________ [Date] __________

Please send this form directly as an attachment to the email address of:
Your dept/div CME Coordinator: ___________ (your email will be your signature)

Or Print out, sign, scan and email this form the email address of:
Your dept/div CME Coordinator:: ___________