THIS FORM REQUIRED **SPEAKER FORM** (Biographical Data and Financial Interest Disclosure) WRITEABLE PDF

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COURSE TITLE: _____

PROGRAM TITLE/DATE: _____

NAME: _____

Mailing Address: _____

Telephone: _____ **EMPLOYER:** _____

Email: _____ Present Position: _____

PROFESSIONAL LICENSE OR CERTIFICATION(S) *(Check all that apply)*

❑ MD ❑ DO ❑ OD ❑ COA ❑ COT ❑ COMT ❑ ROUB ❑ CDOS ❑ CCOA
❑ RN ❑ LPN/LVN ❑ CRNO ❑ CRA ❑ CO ❑ OC(C) ❑ ABO ❑ NCLE ❑ Other:_____

EDUCATION (POST HIGH SCHOOL): *(Include basic preparation through highest degree held.)*

DEGREE	INSTITUTION (NAME, CITY, STATE)	MAJOR AREA OF STUDY	YEAR DEGREE AWARDED
1.			
2.			
3.			

CURRENT AREA(S) OF SPECIALIZATION OR CONCENTRATION *(Check all that apply)*

❑ Administration ❑ Education ❑ Neuro-ophthalmology ❑ Refractive ❑ Surgery
❑ Cataracts ❑ General ophthalmology ❑ Pediatrics/strabismus ❑ Research ❑ Other _____
❑ Cornea ❑ Glaucoma ❑ Plastics ❑ Retina

BIOGRAPHY: *Briefly describe your professional experience, area(s) of expertise, and any certifications, including publications, which qualify you to teach this course.* ***(Do not send CV)***

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CODE OF CONDUCT AND RESPONSIBILITY

Speakers have an obligation to attendees to provide the highest level of relevant education/learning materials and not their own personal beliefs or philosophies. Speakers are encouraged to acknowledge the fact that the audience will be comprised of all races, ages, genders, disabilities, and political affiliations. Every attendee deserves a safe and comfortable learning environment free from any sexist or discriminatory innuendos or language.

FINANCIAL INTEREST DISCLOSURE

For the purpose of this **Financial Interest Disclosure**, "Designated Company" means an entity related directly or indirectly to the manufacture or distribution of lenses, pharmaceuticals, medical devices and instruments, vision care products, or services commonly utilized by ophthalmologists.

Check all boxes that apply and sign below.

❑ Yes ❑ No I, or a member of my family, my professional partnership or corporation, my employer, or co-instructor(s)/co-author(s), currently or within the preceding twelve (12) months have had a financial interest in Designated Company, a financial relationship, advisory capacity with any Designated Company, or entity related to my presentation, poster, or submitted manuscript.

Complete the following if applicable:

❑ Stock shareholder	Company Name:
❑ Consultant, advisor, or employee (compensated or non-compensated)/ Participated as a member of an advisory panel	Company Name:
❑ Educational grant or research funds	Company Name:
❑ Received free/discounted products or services	Company Name:
❑ Received travel stipend or honorarium	Company Name:
❑ Corporate sponsor	Company Name:

SIGNATURE OF INSTRUCTOR

I have read, understand, and agree to comply with the above statement and to the best of my ability, agree to be bound by the "Speaker Code of Conduct and Responsibility." I verify that the content within this document is valid and factual.

Date: _____ **Signature by Mail or Fax:** X_____

or

Date: _____ **Signature by Email:** ❑ This serves as an official signature of authentication for all claims and information included in this form.