

MEMORIAL SLOAN KETTERING CANCER CENTER

Evidence-based Cancer Imaging Program (ECIP)

Conflict of Interest Disclosure Form

The MSK Evidence-based Cancer Imaging Program (ECIP) was created to ensure that patients receive the most appropriate and beneficial imaging studies for their particular needs. Our goal is to provide Appropriate Use Criteria (AUC) to healthcare professionals at the time that advanced diagnostic imaging tests (CT, MRI, or Nuclear Medicine scans) are ordered.

MSK multidisciplinary Imaging Disease Management Teams (IDMTs) are responsible for developing, modifying, or endorsing imaging AUC. In accordance with 42 CFR 414.94, an individual participating in the AUC development or modification process is required to disclose potential conflicts of interest. Disclosures will be made to the ECIP Project Manager using this form. This is in addition to fulfilling MSK's institutional Conflict of Interest policy requirements.

Please provide the information below:

* Required fields

Name: *

Date: *

 

Please indicate your ECIP participation: (select all that apply) *

<input type="checkbox"/> Clinical Council for Cancer Imaging	<input type="checkbox"/> Musculoskeletal IDMT
<input type="checkbox"/> Program Management	<input type="checkbox"/> Neuro-Oncology/Head and Neck IDMT
<input type="checkbox"/> MSK Library	<input type="checkbox"/> Thoracic IDMT
<input type="checkbox"/> Other (please describe below)	<input type="checkbox"/> Prostate IDMT

Please consider all activities since your last disclosure if you are a returning user, or over the past 12 months if you are a new user, when answering the questions below:

SECTION 1: SELF DISCLOSURES

Do you have a direct or indirect financial relationship with a company or organization participating in AUC development that may financially benefit from the AUC? *

Yes

No

If **NO**, please go to Section 2. If **YES**, please indicate nature of financial relationship below:

Organization Name & Address: *

Compensation Arrangement: (select all that apply) *

<input type="checkbox"/> Salary	<input type="checkbox"/> Consulting fees
<input type="checkbox"/> Grant	<input type="checkbox"/> Collaboration agreement
<input type="checkbox"/> Contract	<input type="checkbox"/> No compensation
<input type="checkbox"/> Speaking fees	<input type="checkbox"/> Other

Indirect Financial Relationship (please describe):

Organization Name & Address:**Compensation Arrangement:** (select all that apply)

<input type="checkbox"/> Salary	<input type="checkbox"/> Consulting fees
<input type="checkbox"/> Grant	<input type="checkbox"/> Collaboration agreement
<input type="checkbox"/> Contract	<input type="checkbox"/> No compensation
<input type="checkbox"/> Speaking fees	<input type="checkbox"/> Other

Indirect Financial Relationship (please describe):

For additional disclosures, please contact ecip@mskcc.org.

SECTION 2: RESEARCH ACTIVITY

Are you a Principal Investigator (PI) or co-PI of any grant funded clinical research study that is related to the development of AUC for advanced diagnostic imaging? *

 Yes No

If **NO**, please go to Section 3. If **YES**, please briefly describe below:

For additional disclosures, please contact ecip@mskcc.org.

SECTION 3: FAMILY DISCLOSURES

Does your spouse or minor child have a direct or indirect financial relationship with a company or organization participating in AUC development that may financially benefit from the AUC? *

 Yes No

If **NO**, please go to Section 4. If **YES**, please complete the information below:

Name:

Relationship:

Organization Name & Address:**Compensation Arrangement:** (select all that apply)

<input type="checkbox"/> Salary	<input type="checkbox"/> Consulting fees
<input type="checkbox"/> Grant	<input type="checkbox"/> Collaboration agreement
<input type="checkbox"/> Contract	<input type="checkbox"/> No compensation
<input type="checkbox"/> Speaking fees	<input type="checkbox"/> Other

Indirect Financial Relationship (please describe):

Name:

Relationship:

Organization Name & Address:

Compensation Agreement: (select all that apply)

<input type="checkbox"/> Salary	<input type="checkbox"/> Consulting fees
<input type="checkbox"/> Grant	<input type="checkbox"/> Collaboration agreement
<input type="checkbox"/> Contract	<input type="checkbox"/> No compensation
<input type="checkbox"/> Speaking fees	<input type="checkbox"/> Other

Indirect Financial Relationship (please describe):

For additional disclosures, please contact ecip@mskcc.org.

SECTION 4: OWNERSHIP OR INVESTMENT INTEREST

Do you, your spouse, or minor child who substantially participated in the development of AUC have ownership or investment interests in a company or organization that may financially benefit from the AUC? *

Yes

No

If **NO**, please go to Section 5. If **YES**, please complete the information below:

Relationship:

Organization Name & Address:

Describe ownership or investment interest:

For additional disclosures, please contact ecip@mskcc.org.

SECTION 5: PLEASE READ & SIGN

I understand that the MSK Evidence-based Cancer Imaging Program is required to utilize a publicly transparent process for identifying potential conflicts of interest in the AUC development and modification process, as outlined in 42 CFR 414.94.

To the best of my knowledge, the information provided in this disclosure form is complete and accurate. Potential conflicts of interest may result in recusal or exclusion of individuals from the ECIP AUC process as appropriate.

In accordance with the Final Rule, this information may be made available in a timely fashion to a public request, for a period of not less than 5 years after the most recent published update of the relevant AUC.

By clicking the checkbox below, I, , acknowledge that I have read and accept the above conditions.

*Please type your full name and title - Required **

I acknowledge *

Date: * 

For internal use only:

Date received:  CCCI Review Date:  Disposition: