**Conflict of Interest Declaration**

**INSTRUCTIONS:** Please complete the relevant section (i.e., declaration for patient input or for clinician input).

**Declaration for Patient Input**

**Name:** <Enter full name>

**Patient Group:**<Enter full name>

**Position:** <Enter currently held position>

**Date:** <DD-MM-YYYY>

**I hereby certify** that I have the authority to disclose all relevant information with respect to any matter involving this patient group with a company, organization, or entity that may place this patient group in a real, potential, or perceived conflict of interest situation.

1. Did you receive help from outside your patient group to complete this submission? If yes, please detail the help and who provided it.
2. Did you receive help from outside your patient group to collect or analyze data used in this submission? If yes, please detail the help and who provided it.
3. List any companies or organizations that have provided your group with financial payment over the past two years AND who may have direct or indirect interest in the drug under review.

**Table 1: Conflict of Interest Declaration**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Company** | **Check appropriate dollar range\*** | | | |
| **$0 to**  **$5,000** | **$5,001 to**  **$10,000** | **$10,001 to $50,000** | **In excess of $50,000** |
| Add company name |  |  |  |  |
| Add company name |  |  |  |  |
| Add or remove rows as required |  |  |  |  |

\* Place an X in the appropriate dollar range cells for each company.