



Ministry of Health
BERMUDA NURSING AND MIDWIFERY COUNCIL

P.O. Box: HM1195, Hamilton HM EX, Bermuda | Website: www.bnc.bm
 E-mail: bermudanursingcouncil@gov.bm | Phone: (441) 292-0774 / 278-4910, Fax: (441) 232-1823



Biographical and Conflict of Interest Form

Title of Educational Activity: _____ **Education Activity Date:** _____

Role in Educational Activity: (Check all that apply)

- Nurse Planner
 Content Reviewer
 Planning Committee Member
 Author
 Speaker/Presenter
 RN /RMN/Midwife /physician Subject Matter Expert
 Other _____ Describe: _____

Section 1: Demographic Data

Name with Credentials/Degrees _____

If RN/RMN/Midwife Nursing /Midwifery Degree(s):
 AD
 Diploma
 BSN
 Masters
 Doctorate

If RN/Midwife do you hold a current, valid license to practice as an RN/ Midwife? <input type="checkbox"/> Yes <input type="checkbox"/> No	In what jurisdiction: _____
--	---------------------------------------

If Physician: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Other <input type="checkbox"/> do you hold a current, valid license to practice?	If Other Health Professional: Please list credentials/degrees: _____
--	--

Current Employer and Position/Title: _____	_____
--	-------

Address: _____

Phone Number: _____ **Email Address:** _____

Section 2: Expertise

Please describe professional experience and years of education specific to this educational activity. This information needs to explain why you are qualified to plan and/or speak at this particular program.

Nurses/Midwives: Please summarize information from your curriculum vitae/resume' in lieu of attaching the entire document. This information may also be used to introduce you. **Physicians:** You may attach a short bio in lieu of summarizing your expertise.

Section 3: Actual/Potential Conflict of Interest

The potential for conflict of interest exists when an individual has the ability to control or inflate the content of an educational activity and/or has a relevant financial relationship with a commercial interest,* the products or services of which are pertinent to the content of the educational activity.

*Commercial interest, is defined as any entity producing, marketing, reselling, or distributing healthcare goods or services consumed by or used on patients, or an entity that is owned or controlled by an entity that produces, markets, resells, or distributes healthcare goods or services consumed by or used on patients.

Is there an actual, potential or perceived conflict of interest for yourself or spouse/partner? Yes No

Name with Credentials/Degrees _____

AND complete the table below for all actual or potential conflicts of interest**:

Please check all that apply: Employee Royalty Stockholder Research Support Speakers Bureau
 Consultant Other _____

Section 4: Statement of Understanding

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that relevant financial relationships which I or my spouse/partner have with any commercial company whose product(s) I may discuss in my educational presentation must be disclosed prior to and will be listed in materials for CME certified activities.

An "X" in the box below serves as the electronic signature of the individual completing this Biographical/ Conflict of Interest Form and attests to the accuracy of the information given above.

_____ Electronic Signature Completed by (name and credentials): _____ Date _____

FOR BNC USE: All relevant conflict of interest/potential conflict to interests have been disclosed. Yes No

Additional Conflict of Interest/Bias identified by Committee: NONE IDENTIFIED

NONE IDENTIFIED NO FURTHER ACTION REQUIRED

APPROVED BY:

PRE Committee member Signature _____ Date _____

PRE Committee member Signature _____ Date _____
