CLINICAL CONTENT/PEER REVIEW AND VALIDATION FORM

Name of reviewer: **Speaker:** **Date of submission:**

Activity Title: **Presentation Title:**

Date of Activity:

Activity Type:

Select One:

Financial relationships (company/role)

The above-named speaker has disclosed a relevant financial relationship with an ineligible company(s), (**an entity that produces, markets, sells, re-sells, or distributes healthcare goods or services used by or on patients (financial disclosure attached for convenience)**, and is therefore subject to peer review of the presentation by an individual who has control over the content of the activity and **does not** have a financial relationship

Instructions to Reviewer: Please review the attached course materials for the above-named accredited continuing education activity. As an independent reviewer your role is to ensure that the activity materials are fair, balanced, and free of bias toward the ineligible companies, or manufacturers of products, discussed in the activity.

1. Review for Fair Balance and Bias
Is this activity fair and balanced? ☐ YES ☐ NO

If no, indicate areas of concern:

2. Treatment Recommendations

A. Are treatment recommendations evidence- based? ☐ YES ☐ NO
B. Are treatment recommendations appropriate for the target audience? ☐ YES ☐ NO
C. Are the recommendations contributing to overall improvement in patient care? ☐ YES ☐ NO

List any concerns or comments for Section 2

3. Scientific Validity
Do scientific studies cited conform to standards accepted by the scientific community? ☐ YES ☐ NO

List any concerns or comments relating to #3

4. Educational Objectives

A. Does the educational content support the learning objectives? ☐ YES ☐ NO
B. Are the objectives actionable & measurable? ☐ YES ☐ NO

List any concerns or comments relating to #4

5. Omission and Commission

A. Do any slides or materials need to be deleted? ☐ YES ☐ NO
B. Are there any studies, data or best evidence that is missing? ☐ YES ☐ NO
C. Are there any other issues you would like to raise with the content ? ☐ YES ☐ NO

List any concerns or comments relating to #5:

If yes, please specify:

***** Have you discussed any changes with the author, faculty or content developer?** ☐ YES ☐ NO

CLINICAL CONTENT REVIEWER ATTESTATION AND CONFIRMATION OWNER INTEREST DISCLOSURE

I understand that employees or owners of ineligible companies cannot join SAPS CME activities. I certify the above person is eligible for this Accredited CE activity because they meet one or more of the exceptions checked below:

☐ *When the content of the activity is not related to the business lines or products of their employer/company.*

☐ *When the content of the accredited activity is limited to basic science research, such as pre- clinical research and drug discovery, or the methodologies of research, and they do not make care recommendations.*

☐ *When they are participating as technicians to teach the safe and proper use of medical devices, and do not recommend whether or when a device is used.*

☐ **By selecting this box, I certify that the information provided above is accurate and complete to the best of my knowledge.**

Name: _____