

Office of Continuing Medical Education
SIU SCHOOL OF MEDICINE

Supported Activity Agreement

Company Name: _____ **Contact:** _____
Mailing Address: _____ **City, ST:** _____ **Zip Code:** _____
Email: _____ **Phone:** _____ **Fax:** _____

Agrees to provide financial support by means of:

An educational grant in the amount of \$ _____ >>Insert dollar amount<<

with respect to:

Activity Title: >>INSERT TITLE OF ACTIVITY<<

scheduled for **>>Insert Date<<** at **>>Insert Venue, City & State<<**

The Supported Activity is being certified (sponsored) by **SIU School of Medicine Office of Continuing Medical Education**, an ACCME-accredited continuing education (CME) Provider.

The **Company** and the **Provider** enter into this **Agreement** with the following stipulations:

1. The **Company** and the **Provider** agree to abide by all the principles inherent in the ACCME's Standards for Commercial Support of Continuing Medical Education, the AMA/PRA Guidelines on Gifts to Physicians from Industry, the Accreditation Council for Pharmacy Education's Criterion for Noncommercialism, and the FDA's Final Guidance on Industry-Supported Scientific and Educational Activities.
2. The **Company** agrees not to exert control over the selection of the speaker(s), presenter(s), or other experts for the **Supported Activity**. The **Provider** agrees to acknowledge commercial support granted by the **Company**.
3. The **Company** agrees not to exert control over the scientific content of the **Supported Activity**. The **Company's** role shall be to facilitate, not create or influence, scientific exchange.
4. The **Company**, through the **Provider**, shall ensure that no promotional exhibits or advertisements or any other sales or marketing activity occurs in an obligate path to or in the same room as the **Supported Activity**. Any promotional exhibits or other sales or marketing activity must be clearly identified as promotional and separate from the **Supported Activity**.
5. The **Provider** agrees to assure the **Supported Activity** will be free of commercial bias for or against any product and that, if the **Supported Activity** concerns commercial products, objective information based on scientific methods generally accepted in the medical community regarding said products will be presented.
6. The **Provider** agrees that it is responsible for exercising full control over the **Supported Activity** including selection of speakers, presenters, or other experts for the **Supported Activity** and that if such persons have any financial relationship with the **Company**, their recent and current relationships to the **Company** as well as all significant financial/professional relationships with the manufacturer(s) of any commercial product(s) and/or the provider(s) of any commercial service(s) discussed in the educational presentation will be fully disclosed. If the speaker declines to disclose said relationship(s), this will be made known to the audience.
7. The **Provider** will make a good faith effort to assure speaker disclosure of unapproved use and limitations of data.
8. The **Company** agrees that no additional payment will be given to the course director, planners and/or speakers.
9. The **Company** and the **Provider** acknowledge and agree that the educational grant provided herein has not been determined in a manner which takes into account the volume or value of any referrals, financial relationship(s) or other business arrangement(s) otherwise existing between the parties for which payment may be made, in whole or in part, under any federal or state health care program, including, without limitation, Medicare or Medicaid.

This **Agreement** constitutes the entire agreement between the parties relating to the **Supported Activity** and supersedes all prior writings between the parties. This **Agreement** may be modified only by a writing signed by both parties, which states it is an amendment to this **Agreement**. The **Agreement** shall be governed by and construed in accordance with the laws of the State of Illinois.

SIGNATURE: _____
Company Representative

SIGNATURE: _____
Office of CME Representative

Print Name: _____
Date Signed: _____

Date Signed: _____

SIU School of Medicine Tax ID Number: 37-6005961
Make Check Payable to: Southern Illinois University
Mail check to: Office of CME
PO Box 19602
Springfield, IL 62794-9602