



Mental Health Clinical Advisory Group Public Comment/Testimony Declaration

The purpose of this form is disclosure declaration. Having an interest or affiliation with a corporate organization does not necessarily preclude a speaker from giving comment, but the relationship must be made known to the audience. Completion of this form shall not disqualify a speaker from giving comment.

Instructions: Please read all information. Questions marked with an asterisk (*) are required fields. All required sections must be filled out prior to providing public comment.

SPEAKER INFORMATION	
*Name:	*Date:
*Organization:	*Topic/Drug:
Email Address:	Phone Number:
*Are you an employee of a pharmaceutical manufacturer? (If yes , please skip to the last question) <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Are you an advocate or advocacy organization that receives funding from a Pharmaceutical manufacturer OR a foundation that receives funding from Pharmaceutical entities? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Have you been asked to provide testimony by any advocacy group or Pharmaceutical entity? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*If yes , please identify the organization:	
*If you are a researcher or clinician, do you currently receive grants or other funding from any advocacy or Pharmaceutical entity? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Are you involved in or have you been involved in any research funded directly or indirectly from private funding? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*If yes , please describe the type of compensation:	
Is there any other information about yourself that the committee should know (e.g. participation in clinical trials, direct ownership and control of investments in a pharmaceutical manufacturer, etc.)?	

Signature: _____ **Date:** _____

*Return completed forms to Amanda Parish at: amanda.b.parish@dhsosha.state.or.us