Macklem House, 18 Barrie Street
Queen's University, Kingston ON, K7L 3N6
613.533.6988 seamo@queensu.ca
www.seamo.ca

DISCLOSURE OF SUPPLEMENTARY PROFESSIONAL ACTIVITY

Supplementary Professional Activity is any academic and/or medical professional service provided by a SEAMO physician that does not contribute directly to the achievement of his or her department's clinical, educational, research and/or administrative deliverables, according to the SEAMO Accountability Framework. Such activity may be conducted within or outside the University and/or the signatory hospitals, and may or may not be compensated

ANNUAL DISCLOSURE:
As outlined in the Supplementary Professional Activity Policy, SEAMO physicians are required to disclose, both on an annual basis and when there is a material change during an interim period, the nature of his or her Supplementary Professional Activity and the amount of time devoted to any such activity.

APPROVAL:
A physician's participation in Supplementary Professional Activity is subject to approval by his or her department head or, in the case of a department head, by the SEAMO CEO.

A physician who wishes to engage in Supplementary Professional Activity that is expected to occupy more than 10% of his or her SEAMO-funded time must receive approval from both the Department Head and the SEAMO CEO.

This form is designed to support both the disclosure and approval of supplementary professional activity. Please refer to the Supplementary Professional Activity Policy for additional information.

DISCLOSURE OF SUPPLEMENTARY PROFESSIONAL ACTIVITY

SECTION 1: SEAMO PHYSICIAN DISCLOSURE

Please provide a list of all supplementary professional activities and the estimated time associated with each activity (number of hours per week) for the calendar year.

ACTIVITY	**TIME** (hours per week)

SECTION 2: CERTIFICATION

Physician Certification

In signing this disclosure, I certify that I have reported all Supplementary Professional Activity.

Date: _____

Name: _____

Signature: _____

Department Head and Chief Executive Officer, SEAMO Certification

In signing this disclosure, I approve the reported Supplementary Professional Activity of _____, outlined above.

(physician's name)

Department Head

Date: _____

Name: _____

Signature: _____

SEAMO Chief Executive Officer (where applicable)

Date: _____

Name: _____

Signature: _____