



jCD Author Conflict of Interest Disclosure

The purpose of this form is to provide readers of your manuscript with information about your other interests that could influence how they receive and understand your work. Each author should submit a separate form and is responsible for the accuracy and completeness of the submitted information. The requested information is about resources that you receive directly or indirectly regarding the manuscript and work you have submitted for publication to the *Journal of Cosmetic Dentistry (jCD)*. **You should disclose interactions with ANY entity that would be considered broadly relevant to the work.**

Having an interest in or an affiliation with a corporate organization does not necessarily prevent you from participating as an author, **but the relationship must be made known to the audience.**

Please complete the following:

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Author Name: _____
(please print)

I, the undersigned, declare that all financial interests/arrangements or affiliations with corporate organization(s) (**regardless of amount of compensation**) are indicated below.

Did you receive any financial compensation for this article? If yes, by whom? (Please list below)

Yes

No

<u>AFFILIATION/FINANCIAL INTEREST</u>	Work under Consideration for Publication	Financial Activities Outside the Submitted Work
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Signature: _____

Date: _____

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I am submitting photographs, slides and other materials (collectively, the "material") to the American Academy of Cosmetic Dentistry®, Inc. (the "AACD"). I hereby represent to the AACD that I have the authorization of the patient, _____ **[Insert patient name]**, to use the material and provide it to AACD for its uses, including but not limited to use in AACD publications, advertisements, web sites, exhibit booths, educational programs, social media, other media, and other ways such as reprints, that are deemed appropriate by AACD. If the patient revokes his or her authorization I will immediately provide written notice of the revocation to AACD. I hereby give my consent and permission to the AACD, its officers, agents, employees and affiliates, to use any or all of this material in such manner. I understand that I will receive no compensation for use of the material described in this consent. My consent is freely given to the extent permitted under applicable law. I hereby release and indemnify the AACD, its officers, agents, employees and affiliates from any and all liability for using the material as described in this consent. This release shall apply to any successor or assignee of AACD. I understand that the patient authorization provided by the AACD may not incorporate all applicable law and that I may contact my own legal counsel to review the authorization and this consent.

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- (1) If the dentist/lab technician is the photographer/videographer/illustrator;
 - (2) If another person (such as a professional photographer/videographer/illustrator) is the photographer /videographer/illustrator.
1. ___ I certify that I am the photographer/videographer/illustrator of the attached images taken of the patient or subject. I am the sole owner of all copyrights in said images, and own all right, title and interest thereto. (The default shall be this box if no box is checked).
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For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the photographer/videographer/illustrator/s identified below or the dentist/lab technician hereby grants a non-exclusive perpetual worldwide royalty-free license to the AACD, an authorized agent of the AACD or any successor or assignee of AACD, to reproduce, publish, copy or prepare derivative works based upon the submitted images for the following purposes:

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Dentist and/or Laboratory Technician Signature

Date

Print Dentist and/or Laboratory Technician Name

Complete if dentist/laboratory technician is not the photographer/videographer/illustrator:

Photographer/Videographer/illustrator Signature

Date

Print Photographer/Videographer Name

Patient Release Form

⇒ I am a patient of _____ (my dentist/lab technician). I understand that the purpose of this authorization is so that my dentist/lab technician may submit photographs, slides, video and similar materials (collectively, the “material”) for the AACD’s purposes, such as republication in AACD publications or related web sites. Notwithstanding the foregoing, I place the following additional limitations on this authorization:

⇒ _____. I understand that the material may identify me, and use my real name. I hereby authorize my dentist/lab technician and the AACD, its officers, agents, employees and affiliates, to use any or all of this material in AACD publications, advertisements, Web sites, exhibit booths, educational programs, social media, other media and other ways, such as reprints, which are deemed appropriate by AACD. This authorization shall apply to any successor or assignee of AACD.

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I understand that my dentist/lab technician is not conditioning treatment or eligibility for benefits on whether I grant this authorization. I hereby release my dentist/lab technician and the AACD, its officers, agents, employees, and affiliates from any and all liability for using the material as described in this authorization. I may receive a copy of the signed authorization upon request.

⇒ _____
 Patients Signature _____
 Date

⇒ _____
 Print Patient's Name

If this authorization is signed by a personal representative of the patient (e.g., a parent of a young child) sign above as yourself and complete the following:

⇒ _____
 Personal Representatives Name _____
 Date

⇒ _____
 Relationship to Patient