

# ICMJE DISCLOSURE FORM

**Date:** 11/23/2021

**Your Name:** Helen Seers

**Manuscript Title:** Danish translation and qualitative validation of the tools: Measure Yourself Medical Outcome Profile (MYMOP) and Measure Yourself Concerns and Wellbeing (MYCaW)

**Manuscript Number (if known):** [Click or tap here to enter text.](#)

In the interest of transparency, we ask you to disclose all relationships/activities/interests listed below that are related to the content of your manuscript. "Related" means any relation with for-profit or not-for-profit third parties whose interests may be affected by the content of the manuscript. Disclosure represents a commitment to transparency and does not necessarily indicate a bias. If you are in doubt about whether to list a relationship/activity/interest, it is preferable that you do so.

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4	Consulting fees	<input checked="" type="checkbox"/> <b>None</b> <table border="1" data-bbox="387 259 1533 394"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>									
5	Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	<input checked="" type="checkbox"/> <b>None</b> <table border="1" data-bbox="387 483 1533 584"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>									
6	Payment for expert testimony	<input checked="" type="checkbox"/> <b>None</b> <table border="1" data-bbox="387 831 1533 931"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>									
7	Support for attending meetings and/or travel	<input checked="" type="checkbox"/> <b>None</b> <table border="1" data-bbox="387 1043 1533 1144"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>									
8	Patents planned, issued or pending	<input checked="" type="checkbox"/> <b>None</b> <table border="1" data-bbox="387 1267 1533 1368"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>									
9	Participation on a Data Safety Monitoring Board or Advisory Board	<input checked="" type="checkbox"/> <b>None</b> <table border="1" data-bbox="387 1480 1533 1581"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>									
10	Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	<input checked="" type="checkbox"/> <b>None</b> <table border="1" data-bbox="387 1671 1533 1771"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>									

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I certify that I have answered every question and have not altered the wording of any of the questions on this form.

# ICMJE DISCLOSURE FORM

**Date:** 11/23/2021

**Your Name:** Marie Polley

**Manuscript Title:** Danish translation and qualitative validation of the tools: Measure Yourself Medical Outcome Profile (MYMOP) and Measure Yourself Concerns and Wellbeing (MYCaW)

**Manuscript Number (if known):** [Click or tap here to enter text.](#)

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11	Stock or stock options	<input checked="" type="checkbox"/> None <table border="1" data-bbox="386 259 1533 360"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>							
12	Receipt of equipment, materials, drugs, medical writing, gifts or other services	<input checked="" type="checkbox"/> None <table border="1" data-bbox="386 479 1533 580"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>							
13	Other financial or non-financial interests	<input checked="" type="checkbox"/> None <table border="1" data-bbox="386 696 1533 797"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>							

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Date: 8. oktober 2021

Your name: Anne K. Danielsen

Manuscript title: Danish translation and qualitative validation of the tools: Measure Yourself Medical

Manuscript number (if known):

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3	Royalties or licenses	<input checked="" type="checkbox"/> None	

4	Consulting fees	<input checked="" type="checkbox"/> None	
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Date: 8. oktober 2021

Your name: Birthe Oggesen

Manuscript title: Danish translation and qualitative validation of the tools: Measure Yourself Medical

Manuscript number (if known):

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Date: 8. oktober 2021

Your name: Jacob Rosenberg

Manuscript title: Danish translation and qualitative validation of the tools: Measure Yourself Medical

Manuscript number (if known):

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Date: 8. oktober 2021

Your name: Marie Louise Hamberg

Manuscript title: Danish translation and qualitative validation of the tools: Measure Yourself Medical

Manuscript number (if known):

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Date: 8. oktober 2021

Your name: Mira R. Mekhael

Manuscript title: Danish translation and qualitative validation of the tools: Measure Yourself Medical

Manuscript number (if known):

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# ICMJE DISCLOSURE FORM

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Date: 8. oktober 2021

Your name: Therese Juul

Manuscript title: Danish translation and qualitative validation of the tools: Measure Yourself Medical

Manuscript number (if known):

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