ECCMID-ID Week **Fellows Exchange Program**
Cover Letter and Consent Form

Date_____

Submitted case report title: _____
Diagnosis:_____

ECCMID-ID Week Reviewers;

By my signature below, I, **[_____]** confirm that all contributors are represented and those listed have significantly contributed to the case.

I confirm that the submitted case information and images have not been published previously or submitted for publication elsewhere, and that all contributing authors have agreed to its submission and publication.

I confirm that I am a current member of one of the **ID**Week partner societies. My member ID is:_____

I confirm that patient confidentiality has been respected and HIPAA regulations have been met.

If identifiable patient information appears in the case for **ID**Week reviewers, I confirm that this has been submitted with the patient's consent and that a signed consent form according to HIPAA regulations has been obtained and is on file.

If an image of a physical finding is present (even if it is not identifiable), I confirm that the patient or their legal representative has signed a consent form for the image or images to be published for medical education, and that the consent form is on file.

A complete list of authors includes:

Name of ID Fellow submitting case: _____ Date_____
Signature_____ Contact information:_____
Institution_____

Name of ID Fellow's Program Director or supervising physician: _____
Date_____
Signature_____ Contact information:_____
Institution_____