

ICMJE DISCLOSURE FORM

Date: 1/22/2025

Your Name: Myuri Ruthirakuhan

Manuscript Title: Updates and future perspectives on neuropsychiatric symptoms in Alzheimer's disease

Manuscript Number (if known): ADJ-D-24-02265

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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Time frame: past 36 months									
2	Grants or contracts from any entity (if not indicated in item #1 above).	<div style="display: flex; align-items: center;"> <input type="checkbox"/> None </div> <table border="1" style="width: 100%; margin-top: 5px;"> <tr> <td style="width: 60%;">CIHR REDI award (cofounded by CIHR and BrightFocus Foundation)</td> <td style="width: 40%;">All paid to institution</td> </tr> <tr> <td>ASRP Post-doctoral Fellowship award</td> <td></td> </tr> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> </table>		CIHR REDI award (cofounded by CIHR and BrightFocus Foundation)	All paid to institution	ASRP Post-doctoral Fellowship award			
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4	Consulting fees	<input checked="" type="checkbox"/> None <table border="1"> <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>									
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Your Name: Moyra E. Mortby

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Date: 1/22/2025

Your Name: Jennifer R. Gatchel MD/PhD

Manuscript Title: Updates and future perspectives on neuropsychiatric symptoms in Alzheimer's disease

Manuscript Number (if known): ADJ-D-24-02265

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9	Participation on a Data Safety Monitoring Board or Advisory Board	<input checked="" type="checkbox"/> None <table border="1"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>									
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		Name all entities with whom you have this relationship or indicate none (add rows as needed)	Specifications/Comments (e.g., if payments were made to you or to your institution)						
11	Stock or stock options	<input checked="" type="checkbox"/> None <table border="1"> <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"> <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"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>							

Please place an "X" next to the following statement to indicate your agreement:

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