

## ICMJE DISCLOSURE FORM

Date: 3/4/2021\_\_\_\_\_

Your Name: Tim Wang\_\_\_\_\_

Manuscript Title: Epidemiological study designs and statistical methods for clinical research in oral and maxillofacial surgery: a narrative review

Manuscript number (if known): FOMM-2020-OIOMS-8(FOMM-21-16)

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.

The following questions apply to the author's relationships/activities/interests as they relate to the current manuscript only.

The author's relationships/activities/interests should be defined broadly. For example, if your manuscript pertains to the epidemiology of hypertension, you should declare all relationships with manufacturers of antihypertensive medication, even if that medication is not mentioned in the manuscript.

In item #1 below, report all support for the work reported in this manuscript without time limit. For all other items, the time frame for disclosure is the past 36 months.

|   |  | 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) |
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| <b>Time frame: Since the initial planning of the work</b> |  |  |   |
| 1   | All support for the present manuscript (e.g., funding, provision of study materials, medical writing, article processing charges, etc.)<br><b>No time limit for this item.</b> | <input checked="" type="checkbox"/> None   |   |
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| <b>Time frame: past 36 months</b>                         |  |  |   |
| 2   | Grants or contracts from any entity (if not indicated in item #1 above).   | <input checked="" type="checkbox"/> None   |   |
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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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| 5  | Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events | <input checked="" type="checkbox"/> None |  |
| 6  | Payment for expert testimony   | <input checked="" type="checkbox"/> None |  |
| 7  | Support for attending meetings and/or travel   | <input checked="" type="checkbox"/> None |  |
| 8  | Patents planned, issued or pending   | <input checked="" type="checkbox"/> None |  |
| 9  | Participation on a Data Safety Monitoring Board or Advisory Board  | <input checked="" type="checkbox"/> None |  |
| 10 | Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid            | <input checked="" type="checkbox"/> None |  |
| 11 | Stock or stock options   | <input checked="" type="checkbox"/> None |  |
| 12 | Receipt of equipment, materials, drugs, medical writing, gifts or other services                             | <input checked="" type="checkbox"/> None |  |
| 13 | Other financial or non-financial interests   | <input checked="" type="checkbox"/> None |  |

**Please summarize the above conflict of interest in the following box:**

Mr. Wang has nothing to disclose.

**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.

## ICMJE DISCLOSURE FORM

Date: 3/4/2021\_\_\_\_\_

Your Name: Sung-Kiang Chuang\_\_\_\_\_

Manuscript Title: Epidemiological study designs and statistical methods for clinical research in oral and maxillofacial surgery: a narrative review

Manuscript number (if known): FOMM-2020-OIOMS-8(FOMM-21-16)

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| 1   | All support for the present manuscript (e.g., funding, provision of study materials, medical writing, article processing charges, etc.)<br><b>No time limit for this item.</b> | _X_ None   |   |
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| 2   | Grants or contracts from any entity (if not indicated in item #1 above).   | _X_ None   |   |
|   |  |  |   |
| 3   | Royalties or licenses  | _X_ None   |   |
|   |  |  |   |
| 4   | Consulting fees  | _X_ None   |   |
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| 12 | Receipt of equipment, materials, drugs, medical writing, gifts or other services                             | <input checked="" type="checkbox"/> None                          |  |
| 13 | Other financial or non-financial interests   | <input checked="" type="checkbox"/> None                          |  |

Please summarize the above conflict of interest in the following box:

Dr. Chuang has nothing to disclose.

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.