

ICMJE DISCLOSURE FORM

Date: 10/7/2022

Your Name: ANGELO BAGGIANI

Manuscript Title: Management of COVID micro-areas for asymptomatic or paucisymptomatic patients hospitalized in Azienda Ospedaliera Universitaria Pisana (AOUP, Italy)

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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Date: 10/7/2022

Your Name: MICHELE CRISTOFANO

Manuscript Title: Management of COVID micro-areas for asymptomatic or paucisymptomatic patients hospitalized in Azienda Ospedaliera Universitaria Pisana (AOUP, Italy)

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

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Date: 10/7/2022

Your Name: ANDREA PORRETTA

Manuscript Title: Management of COVID micro-areas for asymptomatic or paucisymptomatic patients hospitalized in Azienda Ospedaliera Universitaria Pisana (AOUP, Italy)

Manuscript number (if known):

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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.

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

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

X 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: 10/7/2022

Your Name: MICHELE TOTARO

Manuscript Title: Management of COVID micro-areas for asymptomatic or paucisymptomatic patients hospitalized in Azienda Ospedaliera Universitaria Pisana (AOUP, Italy)

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

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Your Name: NUNZIO ZOTTI

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Your Name: CHIARA TERRENZIO

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ICMJE DISCLOSURE FORM

Date: 10/7/2022

Your Name: SARA CIVITELLI

Manuscript Title: Management of COVID micro-areas for asymptomatic or paucisymptomatic patients hospitalized in Azienda Ospedaliera Universitaria Pisana (AOUP, Italy)

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

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ICMJE DISCLOSURE FORM

Date: 10/7/2022

Your Name: GIULIA GEMINALE

Manuscript Title: Management of COVID micro-areas for asymptomatic or paucisymptomatic patients hospitalized in Azienda Ospedaliera Universitaria Pisana (AOUP, Italy)

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

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ICMJE DISCLOSURE FORM

Date: 10/7/2022

Your Name: DAVID ROCCHI

Manuscript Title: Management of COVID micro-areas for asymptomatic or paucisymptomatic patients hospitalized in Azienda Ospedaliera Universitaria Pisana (AOUP, Italy)

Manuscript Number (if known): Click or tap here to enter text.

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ICMJE DISCLOSURE FORM

Date: 10/7/2022

Your Name: FRANCESCA DI SERAFINO

Manuscript Title: Management of COVID micro-areas for asymptomatic or paucisymptomatic patients hospitalized in Azienda Ospedaliera Universitaria Pisana (AOUP, Italy)

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

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ICMJE DISCLOSURE FORM

Date: 10/7/2022

Your Name: ELENA LUCACCINI

Manuscript Title: Management of COVID micro-areas for asymptomatic or paucisymptomatic patients hospitalized in Azienda Ospedaliera Universitaria Pisana (AOUP, Italy)

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

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ICMJE DISCLOSURE FORM

Date: 10/7/2022

Your Name: GIULIA GEMIGNANI

Manuscript Title: Management of COVID micro-areas for asymptomatic or paucisymptomatic patients hospitalized in Azienda Ospedaliera Universitaria Pisana (AOUP, Italy)

Manuscript number (if known):

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.

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Time frame: past 36 months			
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3	Royalties or licenses	<input checked="" type="checkbox"/> None	
4	Consulting fees	<input checked="" type="checkbox"/> None	

5	Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	<input type="checkbox"/> X <input type="checkbox"/> None	
6	Payment for expert testimony	<input type="checkbox"/> X <input type="checkbox"/> None	
7	Support for attending meetings and/or travel	<input type="checkbox"/> X <input type="checkbox"/> None	
8	Patents planned, issued or pending	<input type="checkbox"/> X <input type="checkbox"/> None	
9	Participation on a Data Safety Monitoring Board or Advisory Board	<input type="checkbox"/> X <input type="checkbox"/> None	
10	Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	<input type="checkbox"/> X <input type="checkbox"/> None	
11	Stock or stock options	<input type="checkbox"/> X <input type="checkbox"/> None	
12	Receipt of equipment, materials, drugs, medical writing, gifts or other services	<input type="checkbox"/> X <input type="checkbox"/> None	
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Please summarize the above conflict of interest in the following box:

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

X 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: 10/7/2022

Your Name: CATERINA RIZZO

Manuscript Title: Management of COVID micro-areas for asymptomatic or paucisymptomatic patients hospitalized in Azienda Ospedaliera Universitaria Pisana (AOUP, Italy)

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

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ICMJE DISCLOSURE FORM

Date: 10/7/2022

Your Name: FEDERICO GELLI

Manuscript Title: Management of COVID micro-areas for asymptomatic or paucisymptomatic patients hospitalized in Azienda Ospedaliera Universitaria Pisana (AOUP, Italy)

Manuscript Number (if known): Click or tap here to enter text.

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ICMJE DISCLOSURE FORM

Date: 10/7/2022

Your Name: GRAZIA LUCHINI

Manuscript Title: Management of COVID micro-areas for asymptomatic or paucisymptomatic patients hospitalized in Azienda Ospedaliera Universitaria Pisana (AOUP, Italy)

Manuscript Number (if known): Click or tap here to enter text.

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ICMJE DISCLOSURE FORM

Date: 10/7/2022

Your Name: SILVIA BRIANI

Manuscript Title: Management of COVID micro-areas for asymptomatic or paucisymptomatic patients hospitalized in Azienda Ospedaliera Universitaria Pisana (AOUP, Italy)

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

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7	Support for attending meetings and/or travel	<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>									
8	Patents planned, issued or pending	<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>									
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>									
10	Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	<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>									

		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.