**27th Annual Meeting**

**Vision Sciences Research Network (VSRN)**

**Wednesday December 4th 2024**

Université Laval - Pavillon Alphonse-Desjardins

2325, rue de l’Université, Québec QC

**Deadlines**

|  |  |
| --- | --- |
| **Abstracts submission** | **October 16 2024** |

|  |  |
| --- | --- |
| **Online registration** | **November 20 2024** |

# REGISTRATION (free)

# *status*

Check according to your category

**Student** (undergraduate and graduate student, research fellow, medical resident~~,~~ fellow)

**Laboratory staff**

**Regular and associate VSRN member** (professor, researcher, clinician (ophthalmologist, optometrist), and other health and research professional)

**VSRN Non-member**

**Keynote speaker, special guest, sponsor**

# IDENTIFICATION

\*First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Category**

College Student

Undergraduate Student

Master student

PhD student

Postdoctoral fellow

Medical student

Medical resident/Fellow

Research staff / Research Professionnal

Researcher

Ophthalmologist

Other clinician (pediatrician, rehabilitation or other)

Clinician - researcher

Optometrist

Industry representative

Foundation representative

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Starting year of the degree** (for student /fellow only) OR write N/A if non-applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Required fields

**\*Affiliation**

Collège  Specify : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

École de technologie supérieure (ÉTS)

 School of Optometry (UdM)

 École polytechnique (UdM)

 Institut de recherches cliniques de Montréal (IRCM)

 Institut national de la recherche scientifique (INRS)

 Institut Nazareth et Louis-Braille (INLB)

 Bishop’s University

Concordia University

 Université de Montréal (UdM)

Université de Sherbrooke

 Université du Québec à Chicoutimi (UQAC)

Université du Québec à Montréal (UQAM)

 Université du Québec à Rimouski (UQAR)

 Université du Québec à Trois-Rivières (UQTR)

Université du Québec en Abitibi-Témiscamingue (UQAT)

Université du Québec en Outaouais (UQO)

 Université Laval

McGill University

Autre : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Supervisor** (N/A if not applicable)**:**

\***First name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*LAST NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Co-supervisor** (if applicable):

**First name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LAST NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Laboratory Axis**

**Biology and Pathology of Vision**

**Vision Neurosciences**

**Rehabilitation and Social Issues of Visual Disorders**

**Emerging Technologies**

N/A

**\*I wish to reserve:**

a lunch – allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

no lunch

**\*I would like to volunteer during the Annual Meeting.**

Yes

No

\* *Required fields*

**\*I authorize the VSRN to use pictures taken during the annual meeting on which I appear for the website, program or promotional material.**

Yes

No

# SHUTTLE SERVICE

**\*I would like to use the shuttle transportation (Montreal-Québec).**

Yes (round trip)

Yes (one way from Montreal to Quebec City)

Yes (one way returning from Quebec City to Montreal)

No

NB: Details will be provided later

\*Required fields

# ABSTRACT SUBMISSION

**\*1. Preferred presentation type:**

Please note that a preference does not guarantee the presentation type.

Oral presentation \*\*

A wink on my research\*\*

Poster presentation

Infrastructure Poster\*\*\*

Workshop for Residents

\*\* Places are limited. A selection will be made by the Organizing Committee

\*\*\***Infrastructure Poster**: the Organizing Committee will contact you for the submission of your abstract

**\*2. Type de recherche:**

Discovery

Clinical

Preclinical or translational

Epidemiology - Public health

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*3. Supervisor:**

**\* LAST NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*4. Presentation axis:**

**Biology and Pathology of Vision**

**Vision Neurosciences**

**Rehabilitation and Social Issues of Visual Disorders**

**Emerging Technologies**

**\*5. Do you allow the press to broadcast your results following an interview with them?**

Yes

No

\*Required fields

# ABSTRACT

**Instructions**

* Submitted in the language of your choice
* Only this version will be published in the scientific program of the annual meeting.
* **Authors** (First and Last Name)

ex : Jean Tremblay1, Sandra Do2 et Isaac Newton1

* **Affiliations** (Department/Institute/School, University, City, Province, Country)

ex : 1Département des sciences biomédicales, Université de Montréal, Montréal, Québec, Canada; 2Département des sciences de la vision, École d’optométrie, Université de Montréal, Montréal, Québec, Canada.

* The **ABSTRACT - Goal, Methods, Results, Conclusion.s -** maximum **500** words
* **Funding :** Please mention “Vision Sciences Research Network” and “Fondation Antoine-Turmel” or « Fondation des maladies de l’œil » if applicable.

**\*Title**

**\*Authors**

**\*Affiliations**

**ABSTRACT** (500 words maximum)

\***Goal**

**\*Methodology**

**\*Results**

**\*Conclusion.s**

**\*Funding**

Required fields

***POTENTIAL CONFLICT OF INTEREST DISCLOSURE FORM***

The participants in a continuing professional development (CPD) activity should be informed of any affiliation or interests that could influence the presentation of a speaker, a workshop leader or a resource person and that could introduce an orientation or a bias. The intention of disclosure is not to prevent a presenter with a potential conflict of interest from speaking, but to inform the audience in advance of the possible affiliations or conflicts of interests. Since these facts are known openly, the participants can think critically and render an informed judgement on the content of the presentation itself. A conflict of interest can occur when activities or situations place an individual or an organization in front of commercial, financial or non-monetary (such as a political orientation) interests, which could influence or guide comments or come into conflict with the inherent interests related to the duties and responsibilities associated with the participation in a CPD activity. These interests can be related to the organization for which he/she works and/or to the individual, to members of his/her family, to his/her friends or professional associates – past, present or future.

Affiliation means, for example: acting as a consultant for an organization; financial interest means, for example: accepting an invitation, gratuity or remuneration for services rendered, royalties or research funds from a business corporation, or holding a financial interest in a company.

# Declaration of the resource person

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Check all that apply  I am a: | * Member of the scientific committee | * Member of planning committee | * Moderator | * Speaker |
| * Author | * Facilitator |
| * Other (describe) | | | |

In relation or not with the content of this activity, I have had in the past two years, an affiliation or financial or any other interests of any nature with a for-profit or not-for-profit organization, or I find that I must disclose to the audience a particular non-monetary interest or orientation.

No  Yes

**If yes**: specify the type of affiliation (for example: I am an advisor for the XYZ company, I am receiving research funds from the XYZ company, I am in the process of receiving a patent for treatment X, a member of my family works in such field, I am a member or president of such association), the name(s) of the organization/field and the corresponding period of time (please attach an additional sheet as needed).

|  |  |  |
| --- | --- | --- |
| Type of affiliation | Name of the organization | Period |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **This section is to be filled out by speakers, moderators, facilitators and authors only :** | **CIRCLE ONE** | |  |
| I intend to make therapeutic recommendations for medications that have not received regulatory approval (i.e., off-label use of medications). | **Yes** | **No** | You must declare all off-label use to the audience during your presentation. |
| I acknowledge that the [National Standard](https://www.cfpc.ca/CFPC/media/Resources/Communications/CFPC-Conflict-of-Interest-Policy.pdf) requires that any descriptions of therapeutic options use generic names (or both generic and trade names) and do not reflect exclusivity and branding. If no generic name exists, trade names must be used in a consistent manner. | **Yes** | **No** | Failure to do this is a violation of the National Standard and the Mainpro+ Certification Standards. |
| In the presence of significant affiliation or interests, I commit to informing participants of the strategies used to mitigate these potential biases. | **Yes** | **No** |  |

**Acknowledgement**

**Name** *(print)***:**

**Title and date of educational activity: 27th Annual Meeting of the Vision Sciences Research Network**

**December 4 2024**

**I acknowledge that I have reviewed the declaration form’s instructions and guidelines, and that the information above is accurate. I understand that this information will be made available to the participants.**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any individual who fails to disclose their conflicts of interest cannot participate as a scientific committee member, speaker, moderator, facilitator or author of an accredited CPD activity.