

## ICMJE DISCLOSURE FORM

**Date:** 6/14/2022

**Your Name:** Lautaro Badilla

**Manuscript Title:** A novel self-expanding shape memory polymer coil for intracranial aneurysm embolization: one-year follow-up in Chile

**Manuscript Number (if known):** neurintsurg-2022-018996.R1

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 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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4	Consulting fees	<input checked="" type="checkbox"/> None	
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	

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### ICMJE DISCLOSURE FORM

**Date:** 6/5/2022

**Your Name:** Daniel Echeverría

**Manuscript Title:** A novel self-expanding shape memory polymer coil for intracranial aneurysm embolization: one-year follow-up in Chile

**Manuscript Number (if known):** neurintsurg-2022-018996.R1

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		Shape Memory Medical for study-related tasks such as case report form completion, study oversight.	Payment to me.
		Shape Memory Medical for the article processing charge	Reimbursement of the charge.
		Shape Memory Medical provided coils for the study (study sponsorship).	NA.
<b>Time frame: past 36 months</b>			
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## ICMJE DISCLOSURE FORM

**Date:** 6/14/2022

**Your Name:** Martin Einersen

**Manuscript Title:** A novel self-expanding shape memory polymer coil for intracranial aneurysm embolization: one-year follow-up in Chile

**Manuscript Number (if known):** neurintsurg-2022-018996.R1

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## ICMJE DISCLOSURE FORM

**Date:** 6/14/2022

**Your Name:** Pablo Giacaman

**Manuscript Title:** A novel self-expanding shape memory polymer coil for intracranial aneurysm embolization: one-year follow-up in Chile

**Manuscript Number (if known):** neurintsurg-2022-018996.R1

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### ICMJE DISCLOSURE FORM

**Date:** 6/14/2022

**Your Name:** Rodrigo Rivera

**Manuscript Title:** A novel self-expanding shape memory polymer coil for intracranial aneurysm embolization: one-year follow-up in Chile

**Manuscript Number (if known):** neurintsurg-2022-018996.R1

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### ICMJE DISCLOSURE FORM

**Date:** 6/14/2022

**Your Name:** Juan Gabriel Sordo

**Manuscript Title:** A novel self-expanding shape memory polymer coil for intracranial aneurysm embolization: one-year follow-up in Chile

**Manuscript Number (if known):** neurintsurg-2022-018996.R1

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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	

		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)						
<b>11</b>	Stock or stock options	<input checked="" type="checkbox"/> <b>None</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="height: 15px;"> </td><td style="width: 50%;"> </td></tr> <tr><td style="height: 15px;"> </td><td> </td></tr> <tr><td style="height: 15px;"> </td><td> </td></tr> </table>							
<b>12</b>	Receipt of equipment, materials, drugs, medical writing, gifts or other services	<input checked="" type="checkbox"/> <b>None</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="height: 15px;"> </td><td style="width: 50%;"> </td></tr> <tr><td style="height: 15px;"> </td><td> </td></tr> <tr><td style="height: 15px;"> </td><td> </td></tr> </table>							
<b>13</b>	Other financial or non-financial interests	<input checked="" type="checkbox"/> <b>None</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="height: 15px;"> </td><td style="width: 50%;"> </td></tr> <tr><td style="height: 15px;"> </td><td> </td></tr> <tr><td style="height: 15px;"> </td><td> </td></tr> </table>							
<p><b>Please place an "X" next to the following statement to indicate your agreement:</b></p> <p><input checked="" type="checkbox"/> I certify that I have answered every question and have not altered the wording of any of the questions on this form.</p>									