

## ICMJE DISCLOSURE FORM

**Date:** 1/25/2022

**Your Name:** Jordan L. Liles, MD

**Manuscript Title:** Latarjet Procedure to Restore Glenohumeral Stability in a Patient with a Postage Stamp Fracture

**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.

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)						
<b>Time frame: Since the initial planning of the work</b>									
<b>1</b>	All support for the present manuscript (e.g., funding, provision of study materials, medical writing, article processing charges, etc.) <b>No time limit for this item.</b>	<input checked="" type="checkbox"/> <b>None</b> <table border="1" style="width: 100%; height: 40px; margin-top: 5px;"> <tr><td style="width: 50%;"></td><td style="width: 50%;"></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>							<div style="text-align: right; font-size: small; color: #ccc;">Click the tab key to add additional rows.</div>
<b>Time frame: past 36 months</b>									
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<b>11</b>	Stock or stock options	<input checked="" type="checkbox"/> <b>None</b>	
<b>12</b>	Receipt of equipment, materials, drugs, medical writing, gifts or other services	<input checked="" type="checkbox"/> <b>None</b>	
<b>13</b>	Other financial or non-financial interests	<input checked="" type="checkbox"/> <b>None</b>	

**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:** 7/25/2022

**Your Name:** Corey W. Smith, MS, ATC

**Manuscript Title:** Latarjet Procedure to Restore Glenohumeral Stability in a Patient with a Postage Stamp Fracture

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

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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:** 7/25/2022

**Your Name:** Charles A. Su, MD, PhD

**Manuscript Title:** Latarjet Procedure to Restore Glenohumeral Stability in a Patient with a Postage Stamp Fracture

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

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13	Other financial or non-financial interests	<input checked="" type="checkbox"/> None	
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Please place an "X" next to the following statement to indicate your agreement:

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## ICMJE DISCLOSURE FORM

**Date:** 7/25/2022

**Your Name:** Matthew L. Vopat, MD

**Manuscript Title:** Latarjet Procedure to Restore Glenohumeral Stability in a Patient with a Postage Stamp Fracture

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

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## ICMJE DISCLOSURE FORM

**Date:** 7/25/2022

**Your Name:** Matthew T. Provencher, MD, MBA, CAPT, MC, USNR (Ret.)

**Manuscript Title:** Latarjet Procedure to Restore Glenohumeral Stability in a Patient with a Postage Stamp Fracture

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

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<b>Time frame: Since the initial planning of the work</b>									
<b>1</b>	All support for the present manuscript (e.g., funding, provision of study materials, medical writing, article processing charges, etc.) <b>No time limit for this item.</b>	<input checked="" type="checkbox"/> <b>None</b> <table border="1" style="width: 100%; height: 40px; margin-top: 5px;"> <tr><td style="width: 60%;"></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>							<div style="text-align: right; font-size: small; color: #ccc;">Click the tab key to add additional rows.</div>
<b>Time frame: past 36 months</b>									
<b>2</b>	Grants or contracts from any entity (if not indicated in item #1 above).	<input checked="" type="checkbox"/> <b>None</b> <table border="1" style="width: 100%; height: 40px; margin-top: 5px;"> <tr><td style="width: 60%;"></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>							
<b>3</b>	Royalties or licenses	<input checked="" type="checkbox"/> <b>None</b> <table border="1" style="width: 100%; height: 40px; margin-top: 5px;"> <tr><td style="width: 60%;"></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)
4	Consulting fees	<input type="checkbox"/> None	
		Arthrex, Inc	
		Joint Research Foundation (JRF)	
		Arthrosurface	
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 type="checkbox"/> None	
		Arthroscopy	Editorial or governing board member
		Knee	Editorial or governing board member
		Orthopaedics	Editorial or governing board member
		SLACK Inc.	Editorial or governing board member
		AANA	Board or committee member
		AAOS	Board or committee member
		AOSSM	Board or committee member
ASES	Board or committee member		

		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)
		ISAKOS	Board or committee member
		The San Diego Shoulder Institute	Board or committee member
		The Society of Military Orthopaedic Surgeons	Board or committee member
<b>11</b>	Stock or stock options	<input checked="" type="checkbox"/> <b>None</b>	
<b>12</b>	Receipt of equipment, materials, drugs, medical writing, gifts or other services	<input checked="" type="checkbox"/> <b>None</b>	
<b>13</b>	Other financial or non-financial interests	<input checked="" type="checkbox"/> <b>None</b>	

**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.