

## ICMJE DISCLOSURE FORM

**Date:** 7/9/2023

**Your Name:** Kirsi-Maaria Nyrhinen

**Manuscript Title:** **Patient injury claims concerning posterior cruciate ligament injury: A nationwide registry study in Finland.**

**Manuscript Number (if known):** AO-2023-31/R3 RESUBMISSION - (17032)

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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9	Participation on a Data Safety Monitoring Board or Advisory Board	<input checked="" type="checkbox"/> <b>None</b> <table border="1"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>							

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<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="width: 50%; 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>							
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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:** 7/14/2023

**Your Name:** Teemu Helkamaa

**Manuscript Title:** Patient injury claims concerning posterior cruciate ligament injury: A nationwide registry study in Finland.

**Manuscript Number (if known):** AO-2023-31/R3 RESUBMISSION - (17032)

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3	Royalties or licenses	<input checked="" type="checkbox"/> None	
4	Consulting fees	<input type="checkbox"/> None	
		Finnish Workers' Compensation Center	
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 type="checkbox"/> None	
		Pohjola Insurance	
7	Support for attending meetings and/or travel	<input type="checkbox"/> None	
		University Hospital of Helsinki	
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	

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1 0	Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	<input type="checkbox"/> None	
		The Traffic Accident and Patient Injury Board	
		The Social Security Appeal Board	
1 1	Stock or stock options	<input checked="" type="checkbox"/> None	
1 2	Receipt of equipment, materials, drugs, medical writing, gifts or other services	<input checked="" type="checkbox"/> None	
1 3	Other financial or non-financial interests	<input checked="" type="checkbox"/> None	

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## ICMJE DISCLOSURE FORM

**Date:** 7/11/2023

**Your Name:** Ville Bister

**Manuscript Title:** Patient injury claims concerning posterior cruciate ligament injury: A nationwide registry study in Finland

**Manuscript Number (if known):** AO-2023-31/R3 RESUBMISSION - (17032)

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# ICMJE DISCLOSURE FORM

**Date:** 7/16/2023

**Your Name:** Arne Schlenzka

**Manuscript Title:** Patient injury claims concerning posterior cruciate ligament injury: A nationwide registry study in Finland.

**Manuscript Number (if known):** AO-2023-31/R3 RESUBMISSION - (17032)

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7	Support for attending meetings and/or travel	<input checked="" type="checkbox"/> None	
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**Date:** 7/11/2023

**Your Name:** Henrik Sandelin

**Manuscript Title:** Patient injury claims concerning posterior cruciate ligament injury: A nationwide registry study in Finland.

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**Your Name:** Jerker Sandelin

**Manuscript Title:** Patient injury claims concerning posterior cruciate ligament injury: A nationwide registry study in Finland.

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# ICMJE DISCLOSURE FORM

**Date:** 7/10/2023

**Your Name:** Arsi Harilainen

**Manuscript Title:** Patient injury claims concerning posterior cruciate ligament injury: A nationwide registry study in Finland

**Manuscript Number (if known):** AO-2023-31/R3 RESUBMISSION - (17032)

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Time frame: Since the initial planning of the work								
<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%; border-collapse: collapse; margin-top: 5px;"> <tr><td style="width: 60%; height: 20px;"></td><td style="width: 40%;"></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></td><td style="text-align: right; font-size: small;">Click the tab key to add additional rows.</td></tr> </table>						Click the tab key to add additional rows.
	Click the tab key to add additional rows.							
Time frame: past 36 months								
<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%; border-collapse: collapse; margin-top: 5px;"> <tr><td style="width: 60%; height: 20px;"></td><td style="width: 40%;"></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></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)
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 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	

		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>10</b>	Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	<input checked="" type="checkbox"/> <b>None</b>	
<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.