

## ICMJE DISCLOSURE FORM

**Date:** 1/8/2025

**Your Name:** Konsta Koivunen

**Manuscript Title:** Change in Functional Profile After Lumbar Spinal Surgery: a register-based study among 1,451 patients undergoing surgery on the lumbar spine

**Manuscript Number (if known):** AO-2024-219/R3

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.

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12	Receipt of equipment, materials, drugs, medical writing, gifts or other services	<input checked="" type="checkbox"/> None	
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		<input type="text"/>	<input type="text"/>
13	Other financial or non-financial interests	<input checked="" type="checkbox"/> None	
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		<input type="text"/>	<input type="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:** 1/4/2025

**Your Name:** Sara Widbom-Kolhanen

**Manuscript Title:** Change in Functional Profile After Lumbar Spinal Surgery: a register-based study among 1,451 patients undergoing surgery on the lumbar spine

**Manuscript Number (if known):** AO-2024-219/R3

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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:** 6/1/2025

**Your Name:** Katri Pernaa

**Manuscript Title:** Change in Functional Profile After Lumbar Spinal Surgery: a register-based study among 1,451 patients undergoing surgery on the lumbar spine

**Manuscript Number (if known):** AO-2024-219/R3

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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## ICMJE DISCLOSURE FORM

**Date:** 1/4/2025

**Your Name:** Jari Arokoski

**Manuscript Title:** Change in Functional Profile After Lumbar Spinal Surgery: a register-based study among 1,451 patients undergoing surgery on the lumbar spine

**Manuscript Number (if known):** AO-2024-219/R3

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## ICMJE DISCLOSURE FORM

**Date:** 1/4/2025

**Your Name:** Mikhail Saltychev

**Manuscript Title:** Change in Functional Profile After Lumbar Spinal Surgery: a register-based study among 1,451 patients undergoing surgery on the lumbar spine

**Manuscript Number (if known):** AO-2024-219/R3

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<b>Time frame: Since the initial planning of the work</b>									
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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" 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>									
10	Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	<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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<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: 20px;"></td><td style="width: 50%;"></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></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="width: 50%; height: 20px;"></td><td style="width: 50%;"></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></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.