

ICMJE DISCLOSURE FORM

Date: 12/22/2022

Your Name: Charlotte Brauer

Manuscript Title: Gravide og ergonomiske risikofaktorer i arbejdsmiljøet

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.

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ICMJE DISCLOSURE FORM

Date: 12/22/2022

Your Name: Camilla Sandal Sejbæk

Manuscript Title: Gravide og ergonomiske risikofaktorer i arbejdsmiljøet

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Date: 12/21/2022

Your Name: Jens Peter Ellekilde Bonde

Manuscript Title: Gravide og ergonomiske risikofaktorer i arbejdsmiljøet

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

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Date: 12/21/2022

Your Name: Luise Mølenberg Begtrup

Manuscript Title: Gravide og ergonomiske risikofaktorer i arbejdsmiljøet

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Date: 12/21/2022

Your Name: Mimmi Torp

Manuscript Title: Gravide og ergonomiske risikofaktorer i arbejdsmiljøet

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9	Participation on a Data Safety Monitoring Board or Advisory Board	<input checked="" type="checkbox"/> None <table border="1"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></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"/> None <table border="1"> <tr><td></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)						
11	Stock or stock options	<input checked="" type="checkbox"/> None <table border="1"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>							
12	Receipt of equipment, materials, drugs, medical writing, gifts or other services	<input checked="" type="checkbox"/> None <table border="1"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>							
13	Other financial or non-financial interests	<input checked="" type="checkbox"/> None <table border="1"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></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.