

## ICMJE DISCLOSURE FORM

**Date:** 20/11/2023  
**Your Name:** Valentina Más  
**Manuscript Title:** Predictores de riesgo de deterioro cognitivo leve en una población de hipertensos  
**Manuscript Number (if known):** http://dx.doi.org/10.7775/rac.es.v91.i6.20710

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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Please place an "X" next to the following statement to indicate your agreement:

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Prof. Adj. Dra. Valentina Mas  
Clínica Médica "3"- Facultad Medicina- UdelaR

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**Date:** 20/11/2023  
**Your Name:** Mario Llorens  
**Manuscript Title:** Predictores de riesgo de deterioro cognitivo leve en una población de hipertensos  
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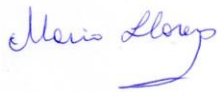
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(Ex) Prof. Adgo. Dr. Mario Llorens  
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Residente Dra. Ximena Cuba  
Clínica Médica "3"- Facultad Medicina- UdelaR

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**Your Name:** Paola Sposito  
**Manuscript Title:** Predictores de riesgo de deterioro cognitivo leve en una población de hipertensos  
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Prof. Agda. Dra. Paola Sposito  
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**Manuscript Title:** Predictores de riesgo de deterioro cognitivo leve en una población de hipertensos  
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7	Support for attending meetings and/or travel	<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>							
8	Patents planned, issued or pending	<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>							
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>							
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>							

		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>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>							

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.



Asistente Dra. Maria Noel Rivero  
Clínica Médica "3"- Facultad Medicina- UdelaR