



MEDICAL STAFF CONFLICT OF INTEREST DISCLOSURE FORM

While important resources to ensure quality patient care and achieve relationships with the stakeholders should be compensated, it is never appropriate for an individual's actions or decisions made in the course of his/her Hospital activities to be determined or influenced by considerations of personal financial gain. Such behaviors call into question the professional objectivity and ethics of the individual and it also reflects negatively on the Hospital. St Joseph's Hospital Health Center and affiliates are institutions of public trust and the medical staff must conduct their affairs in ways that will not compromise the integrity of the hospital.

The purpose of this form is to permit the identification and evaluation of potential conflicts of interests. Having an affiliation or answering, "Yes" to any of the following does not necessarily mean that there is evidence of wrongdoing; it means only that evaluation, and in some cases, approval and oversight may be required.

1. To your knowledge, do you, or does any member of your family or any business partner, have or expect to acquire any financial interest in an entity,

a. Whose business is considerably related to the proposed technology and/or a pharmaceutical product? Yes No

Select all financial interests that apply:

- Personal Investment
- Personal Income, Gifts or Other Consideration
- Ownership or Partnership Interest
- Consulting
- Equity Interests, Stock Options or Royalty Income
- Service in a Fiduciary Role (i.e. Director, Officer)
- Other Financial Benefit: _____

b. Which may be a potential vendor of the proposed technology and/or a pharmaceutical product? Yes No

c. Relevant Financial Interest Levels of Support:
 None Modest: less than or equal to \$10,000 Significant: greater than \$10,000

2. I have attached a list of all my affiliations with any person, firm, organization, or corporation with which I have reason to believe St Joseph's Hospital Health Center does business.

- NOT APPLICABLE, as I do not believe that my affiliates do business with St. Joseph's Hospital Health Center.
- SEE ATTACHED LIST

3. I have attached a list of my consulting arrangements, whether or not I believe that they may involve potential conflict of interest.

- NOT APPLICABLE, as I do not have any consulting arrangements.
- SEE ATTACHED LIST

4. I shall amend these two lists within 30 days whenever my affiliations or duties change and submit them to the Vice President for Medical Affairs.

5. If I become aware that any member of my family is engaged in business with a corporation with which I believe St. Joseph's Hospital Health Center does business, I shall disclose my relationship to the Vice President for Medical Affairs within 30 days.
6. I understand that I am not to participate in any decision or vote on an issue in which I may have conflicts of interest.

I understand that any changes in the information reported, or any new information, which needs to be reported, must be reported promptly by written communication to the Vice President for Medical Affairs.

Signature

Date

Print Name

Return completed disclosure form with any supporting documentation to the address listed below:

St. Joseph's Hospital Health Center
Attn: Vice President for Medical Affairs
301 Prospect Street
Syracuse, NY 13203
Fax: (315) 448-6161