APIC MINNESOTA

**Policy/Procedure**

**Policy # 05**

# CONFLICT OF INTEREST DECLARATION

Name: _____

Employer Name: _____

Employer Address: _____

Position: _____

Your current leadership position within APIC MN: _____

I have read and agree with my APIC MN Job description: Yes ☐ No ☐

Has your principal employer changed since your last declaration? Yes ☐ No ☐

Do you serve on other professional boards or hold an office or serve in a "leadership role" in another professional organization? Yes ☐ No ☐

If "yes" please list: _____

Do you have any "official title or position" in any other health care related company either for profit or non-profit (other than with your current employer)? Yes ☐ No ☐

If "yes" please list: _____

What material revenue sources ($\geq$ 10% of your gross annual income) could impact your decision-making for APIC MN? (For the purposes of determining materiality, include estimated value of expenses paid for reimbursed, i.e., airfare, hotel, meals, spouse or family subsidies as well as direct payments). Also, if you are aware of any major investments or holdings in companies that may represent a conflict or influence your decision-making, disclose them here:

_____

_____

_____

Date: _____ Signature:_____

(Placing name in above space, signifies signature)

Form Updated Oct. 2010 for use beginning 2011