

DISCLOSURE FORM

Directions: Please complete the form below on an annual basis and return to your department chair by August 1st. If you **DO NOT** have any items to disclose, from the previous academic year, please complete sections A & B. If you **DO** have items to disclose from the previous academic year, please complete sections A & B and the appropriate items in section C.

Section A: Contact Information

First Name	Last Name	Title
Department	Phone Number	Email

Section B: Disclosure Statement

By executing this document, I attest that:

I have read and understand the West Virginia University School of Medicine conflict of interest policy. I recognize that I must disclose any relevant material financial interests and/or benefits that might bias, or that might reasonably be perceived as biasing, my actions or statements in relation to patient care or other clinical, educational, research, or administrative responsibilities to the West Virginia University School of Medicine, University Health Associates or West Virginia University Hospitals. Furthermore, should this change within the next twelve (12) months, I understand that I will have to update this form. Such material interests and benefits include but are not limited to:

- Stock ownership or options (> \$10,000 or 5% equity) by myself or a member of my immediate family that might bias or be reasonably be perceived as biasing my actions or statements in relation to patient care or other clinical, educational, research, or administrative responsibilities to the West Virginia University School of Medicine, University Health Associates or West Virginia University Hospitals;
- Paid consultancy, advisory board services etc. as defined in the institutional conflict of interest policy;
- Grants or contracts from for-profit or commercial entities (> \$10,000 threshold per commercial entity);
- Intellectual property rights (patents, copyrights, trademarks, licensing agreements, and royalty arrangements);
- Honoraria or speakers' fees from activities as defined in the institutional conflict of interest/vendor interaction policy;
- Gifts per year per commercial entity (only if the amount exceeds \$25.00 per instance; excludes medical textbooks or other resident/patient educational materials)
- Industry sponsored travel
- Meals and hospitality per year per commercial entity (only if the amount exceeds \$25.00 per instance).

Please check either the "no" or "yes" statement below:

_____ No, neither I nor any member of my immediate family has any relevant financial relationships as described above.

_____ Yes, either I or a member of my immediate family does have relevant financial relationships as described above. Please describe below:

Signature

Date

