

Conflict of Interest Disclosure Form

1. Name: _____ Date: _____

2. In what capacity do you represent the Consortium for Advanced Practice Providers? Please mark all that apply.

- Member of <u>Consortium's Board of Directors</u>? Yes/No
 - If you are officer, what is your position? _____
- <u>Site Visitor</u>?
- Other _____

3. I affirm the following:

I have received a copy of, read, and understand the Consortium's Conflict of Interest Policy.
______(initial)

Yes/No

- I agree to comply with the policy. _____ (initial)
- I understand that Consortium is charitable and in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more tax-exempt purposes. _____ (initial)

4. Disclosures:

Do you currently have a financial, professional, or personal interest (current or potential), including a compensation arrangement, as defined in the Conflict of Interest policy with Consortium? **Yes / No**

- If yes, please describe it:
- If yes, has the financial, professional, or personal interest been disclosed, as provided in the Conflict of Interest policy?

In the past, have you had a financial, professional, or personal interest, including a compensation arrangement, as defined in the Conflict of Interest policy with Consortium? *Yes No*

- If yes, please describe it, including when (approximately):
- If yes, has the financial, professional or personal interest been disclosed, as provided in the Conflict of Interest policy?

Signature of In	erested Person
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Panel Decision:



No Actual or Perceived conflict of Interest

Actual Conflict of Interest is Present



Perceived Conflict of Interest is Likely

Plan to manage conflict of interest:

I understand, accept and agree to comply with the above described management plan.

Signature of Interested Person Acknowledging Panel Decision

Date

Date

Signature of Panel Reviewer

Date of Review

Approved and Revised 12/30/2022