CONFLICT OF INTEREST DISCLOSURE FORM

COMPLETE THIS PAPER FORM IF YOU DO NOT HAVE ACCESS TO THE EMPLOYEE PERFORMANCE MANAGEMENT SYSTEM (HALOGEN).

Email performancedevelopment@conehealth.com and request access to update and submit the form electronically.

SECTION I

Cone Health Conflict of Interest policy requires disclosure of relationships that may create an actual or perceived conflict of interest (policy: ER-HRD-2005-12). An actual or perceived conflict of interest may exist if a Cone Health team member has any type of business or economic relationship with an individual or organization that may interfere with such person's ability to make independent judgements or decisions on behalf of Cone Health or its patients. This form provides an opportunity for you to disclose all relationships that may pose an actual or perceived conflict of interest.

SECTION II – GENERAL INFORMATION

Please supply the following information:

Last Name	First Name	Employee ID *(if applicable)*
Title	Office Phone	E-Mail Address

SECTION III

REVIEW THE FOLLOWING LIST OF EXAMPLES OF RELATIONSHIPS AND ACTIVITIES WHICH REQUIRE DISCLOSURE AND SELECT ALL THAT APPLY. ENTER DETAILS DESCRIBING ANY RELATIONSHIPS YOU SELECT.

1. ☐ Received any type of remuneration in return for performing any consulting activities on behalf of a Pharmaceutical, Device, Biological or Medical Supply Manufacturer, or other healthcare industry company.

   DETAILS:

2. ☐ Received remuneration or transfers of value from a Pharmaceutical, Device, Biological or Medical Supply Manufacturer or Medical Education Company for educational sessions (not as a speaker) or materials.

   DETAILS:

3. ☐ A Pharmaceutical, Device, Biological or Medical Supply Manufacturer, other healthcare industry company made a charitable contribution on your behalf, payed an honorarium to you, reimbursed you for out-of-pocket expenses (travel, lodging, food, or beverage), provide you with tickets for entertainment events, or gave you a gift.

   DETAILS:

4. ☐ Served on the Board of Directors, Board of Trustees, or other board for a Pharmaceutical, Device, Biological, or Medical Supply Manufacturer, other outside organization, or financial investment firm that has any direct or indirect relationship with Cone Health or could be considered a competitor.

   DETAILS:

5. ☐ You or your spouse have direct or indirect Equity Interest in the form of stock/stock options or royalties from a Pharmaceutical, Device, Biological, Medical Supply Manufacturer, or any other healthcare industry company.

   DETAILS:

6. ☐ You or your spouse have ownership interest in any property being leased to Cone Health or in any property planned to be purchased or leased by Cone Health.

DETAILS:

7. ☐ You and/or your spouse have ownership interest in a Group Purchasing Organization (GPO) or Physician-Owned Distributors (POD) and have the authority to directly or indirectly influence purchasing decisions at Cone Health.

DETAILS:

8. ☐ A member of your family (excluding your spouse) has ownership interest in a Group Purchasing Organization (GPO) or Physician-Owned Distributorship (POD) and has the authority to directly or indirectly influence purchasing decisions at Cone Health.

DETAILS:

9. ☐ You have current or previous direct or indirect affiliation with a provider or supplier that- (1) has uncollected debt (2) has been or is subject to a payment suspension under a federal health care program (3) has been or is excluded by the Office of Inspector General (OIG) from Medicare, Medicaid, or CHIP, or (4) has had its Medicare, Medicaid, or CHIP billing privileges denied or revoked.

DETAILS:

10. ☐ You are involved in a relationship that may be a conflict of interest according to Cone Health policy, but it is not listed in #1 through #9 above.

DETAILS:

11. ☐ You are not involved in any of the above relationships or activities that require conflict of interest disclosure.

SECTION IV – ATTESTATION

I attest that I understand and have complied with Cone Health's Conflict of Interest Policy. I further certify that the disclosure responses provided in this questionnaire are accurate and complete and that I have fully disclosed all relationships and activities to the best of my knowledge. If changes occur in my relationships or activities throughout the year, I will immediately update my information using this form and submitting to my manager. If I have access to the Employee Management System, Halogen, I will update my information by emailing performancedevelopment@conehealth.com and request access to update and submit the form electronically. I agree to cooperate with the Cone Health Legal Department, Audit and Compliance Services, Human Resources, Conflict of Interest Committee, and other appropriate individuals to manage any actual or potential conflicts. By signing your name and date below, you attest to the statement above.

Sign your full name and date in the fields below:

_____	_____
Employee Signature	***Date***