



CONFLICT OF INTEREST DISCLOSURE FORM

At Cone Health and Triad HealthCare Network (THN) we are committed to ensuring that our decisions are full of integrity and free from actual or perceived influence. Our conflict-of-interest policies outline our responsibility to disclose relationships that may create an actual or perceived conflict of interest. A conflict of interest may occur when someone's outside activities or personal interests overlap with their Cone Health or THN role and could interfere with, or appear to interfere with, their ability to perform their work objectively and effectively for Cone Health or THN. Click the links below to review applicable Cone Health and THN policies:

- [Code of Conduct](#)
- [Compliance and Integrity Plan](#)
- [Conflict of Interest](#)
- [Business Courtesies, Gifts, and Supplier Relations](#)
- [IRB Guideline: Conflicts of Interest in Research](#)
- [THN Conflict of Interest policy](#)

SECTION 1 – EMPLOYEE INFORMATION

Name:	Department:
Employee ID:	Job Title:
Phone:	Email Address (If not in Outlook):

INSTRUCTIONS

STEP ONE:

- REVIEW SECTION II FOR THE LIST OF EXAMPLES OF RELATIONSHIPS AND ACTIVITIES WHICH REQUIRE DISCLOSURE.
- SELECT YES OR NO FOR EACH EXAMPLE WHICH APPLIES. IF YOU SELECT YES, THEN PLEASE INCLUDE DISCLOSURE DETAIL IN THE COMMENT BOX.

STEP TWO:

- REVIEW FORM FOR ACCURACY AS WELL AS SECTION III FOR ATTESTATION. SIGN THE ATTESTATION.
- SAVE FORM AND RETURN TO COMPLIANCE@CONEHEALTH.COM.

Form: Form: Conflict of Interest Disclosure Form

SECTION II – DISCLOSURE DETAILS

Competency	Rating	Comments:
<p>#1 - Outside Activities Have you performed any paid or unpaid activities outside of Cone Health and THN (including any consulting, advisory, board membership, speaking, survey or publication) for an organization that has a business relationship with Cone Health or THN? Have you provided clinical care in another setting? Have you performed duties that overlap with or are similar in ways to your role with Cone Health or THN? If yes, please describe.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>#2 - Significant Relationships Do you have a family or business relationship with Cone Health or THN key personnel, including board members, officers, senior management, your supervisor, or your direct reports? If yes, please list the name(s) and describe.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>#3 - Direct Reimbursement and Gifts Has a healthcare industry company or organization doing business with Cone Health or THN made a charitable contribution on your behalf, paid an honorarium to you, reimbursed you for out-of-pocket expenses (travel, lodging, food, or beverage), provided you with tickets for entertainment events, or gave you a gift. If yes, please describe.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>#4 - Property Interests Do you or your immediate family members have any direct or indirect material or ownership interests in the sale, purchase, exchange, or leasing of property where Cone Health or THN was involved? If yes, please describe.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>#5 - Business Ownership Interests Do you or your immediate family member have direct or indirect equity interest in the form of stock/stock options or other ownership interests in a healthcare organization doing business with Cone Health or THN?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>#6 - Financial Interests Do you or your immediate family member have any arrangements or ownership interests, direct or indirect, in any financial transactions involving Cone Health or THN (other than employment and employee benefits) from which you or your immediate family members may have benefitted? If yes, please describe.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>#7 - Claims of Litigation Have you or your immediate family member (either directly or indirectly through another person, business, or entity) participated in a legal suit, claim, proceeding, or litigation in which Cone Health or THN was a party? If yes, please describe.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>#8 - Affiliation Relationships Do you have a 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.</p> <p>*An affiliation relationship is defined as any of the following:</p> <ul style="list-style-type: none"> • A 5% or greater direct or indirect ownership interest that you have in another organization. • A general or limited partnership (regardless of the percentage) that you hold in another organization. • An organization in which you have operational or managerial control over (or directly or indirectly conduct) the day-to-day operations, either under contract or through some other arrangement, regardless of whether you are paid by or an employee of the organization. • A role where you are acting as an officer or director of a corporation. • Reassignment of provider billing benefits to another Medicare provider or supplier (specific to Cone Health medical staff members). 	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Competency	Rating	Comments:
<p>#9 - Other Relationships Are you involved in a relationship that may be a conflict of interest according to Cone Health or THN policy, but it is not listed in #1 through #8 above? If so, please select the Yes rating and describe 1 in detail the conflict in the comment box.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION III – ATTESTATION

I attest that I understand and have complied, and will continue to comply, with Cone Health’s and/or THN’s applicable conflicts of interest policies listed at the beginning of this form.

I further certify that the responses provided in this questionnaire are accurate and complete, and that I have fully disclosed all relationships, affiliations, 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 on this form by locating it in the conflict-of-interest policy. I agree to cooperate with the Cone Health Legal Department, Audit and Compliance Services, Human Resources, Conflict of Interest Committees, and other appropriate individuals to manage any actual or potential conflicts.

I understand that by signing this form, I attest to the information that I have provided as well as the statement above.

Signature:	Date:
Printed Name:	