Marshall University
Joan C. Edwards School of Medicine
POTENTIAL CONFLICT OF INTEREST DISCLOSURE FORM

List any financial relationship (including any investment or ownership interest in or compensation arrangement) which you or an immediate family member have with any health care provider (such as any nursing home, home health agency, hospice, hospital, ambulatory surgical center, dialysis facility, or other physician group) or with any health care supplier (such as a durable medical equipment supplier, laboratory or rehabilitation therapy company) or any medical device manufacturer or pharmaceutical company.

Describe any personal, professional, financial or other interest which others might reasonably regard as interfering with properly and loyally performing duties as a Faculty member of the School of Medicine.

All information submitted on this form is true to the best of my knowledge and belief.

(Signature of Applicant)

(Date)