Conflict of Interest (COI) Disclosure Form Questions

The Conflict of Interest Disclosure Form is available via a secure web-based form. Those Individuals required to complete an annual disclosure will be sent, via email, a personal link to the COI Disclosure Form upon hire or appointment and annually thereafter. This link should not be forwarded or shared. This link will allow the respondent to leave and return to the form before submitting it. Those Individuals needing to complete the form who have not received the link, can access the form at: www.amc.edu/COI.

**For purposes of this COI Disclosure, an Albany Med Health System entity includes any entity over which the Albany Med Health System has direction and control, including but not limited to: Albany Med Health System (formerly Albany Medical Center), Albany Medical Center Hospital, Albany Medical College, Albany Med Health System Staffing Alliance, Center for Donation and Transplant, Columbia Memorial Hospital, Glens Falls Hospital, Healthcare Partners of Saratoga (Malta Med), The Saratoga Hospital, Visiting Nurse Association of Albany, Inc., Visiting Nurse Association of Albany Home Care Corporation, and the respective Foundations.*

The below table lists the questions contained in the web-based form.

Section I. General Information		
1.	Provide your **legal name:** • First Name • Middle Name • Last Name	
2.	If you have another name, provide it in the space below (otherwise leave blank):	
3.	Primary Residence: • Street Address Line 1 • Street Address Line 2 • City • State • Zip	
4.	Best ways to contact you: • Email • Phone	
Section II. Role		
1.	Are you a Member of the Board of Directors, Board of Governors, or Board of Trustees at a System entity? Yes/No	
1a.	Select all entities where you are a Member of the Board: • Albany Med Health System (formerly Albany Medical Center) • Albany Medical Center Hospital • Albany Medical College	Displays if Section II Q1 = Yes

	• AMC Foundation, Inc. • Albany Med Health System Staffing Alliance, LLC • Center for Donation and Transplant • Columbia Memorial Hospital • Columbia Memorial Hospital Foundation • Glens Falls Hospital • Glens Falls Hospital Foundation • Healthcare Partners of Saratoga (Malta Med) • The Saratoga Hospital • The Saratoga Hospital Foundation • Visiting Nurse Association of Albany, Inc. • Visiting Nurse Association of Albany Home Care Corporation • Visiting Nurses Foundation, Inc. • Other o Identify the Other System entity where you are a Member of the Board	
2.	Are you a Non-Board Member who serves on a Committee with Board-delegated authority? Yes/No	
2a	Select <u>all entities</u> where you serve on such Committee: *Same selection options as Section II, Question 1a*	Displays if Section II Q2 = Yes
3	Are you an Officer for an Albany Med Health System entity? Yes/No	
3a.	Select <u>all entities</u> where you are an Officer: *Same selection options as Section II, Question 1a*	Displays if Section II Q3 = Yes
4.	Are you an **employee** of an Albany Med Health System entity, do you have a **Professional Service Agreement** with an Albany Med Health System entity, or do you have authority or responsibility at an Albany Med Health System entity that is similar to an employee? Yes/No	
4a.	Is your annual compensation from the Albany Med Health System greater than $150,000? Yes/No (Note: This question is required to determine your status as a Key Employee).	Displays if Section II Q4 = Yes
4a1.	Do any of the following apply? (a) Do you have responsibilities, powers or influence over a System entity that is similar to those of an officer, director or trustees or (b) do you manage a discrete segment or activity that represents 10% or more of a System entity's assets, income or expenses or (c) do you have or share authority to control or determine 10% or more of a System entity's capital expenditures, operating budget, or employee compensation? Yes/No	Displays if Section II Q4a = Yes
4b.	Are you on a Committee that can influence the decisions or activities of an Albany Med Health System entity? Yes/No • Identify the **Committee** and the name of the **Committee Chair**	Displays if Section II Q4 = Yes
4c.	Select the <u>primary</u> System entity where you are an employee, bound by a Professional Service Agreement, or have authority or responsibility similar to an employee: *Select One - Same selection options as Section II, Question 1a*	Displays if Section II Q4 = Yes

4d.	Provide details about your primary position: • Title • Department • Manager or Department Chair First Name • Manager or Department Chair Last Name • Manager or Department Chair Work Email	Displays if Section II Q4 = Yes
4e.	Select other entities where you are employed, bound by a Professional Services Agreement or have authority or responsibility similar to an employee, if applicable: *Same selection options as Section II, Question 1a*	Displays if Section II Q4 = Yes
4f	Do you have reporting responsibilities to other Individuals (not already Identified in this disclosure) at the Albany Med Health System? Yes/No	Displays if Section II Q4 = Yes
4f1.	Identify the name, title and department for each of the other Managers, Department Chairs, Supervisors, or other Individuals to whom you report:	Displays if Section II Q4f = Yes
5	Are you a Member of or Affiliate to the Medical Staff at an Albany Med Health System entity? Respond "yes" if you are on the Medical Staff as a physician or as an allied health professional (registered physician assistant, nurse practitioner, psychologist, etc.). Yes/No	
5a.	Please provide your NPI Number below. If you do not have one, leave it blank.	Displays if Section II Q5 = Yes
5b.	Select all System entities where you are an allied health professional or a Member of or Affiliate to the Medical Staff: • Albany Medical Center Hospital and/or Albany Med Integrated Delivery System (IDS) • Columbia Memorial Hospital and/or Columbia Memorial Integrated Delivery System (IDS) • Glens Falls Hospital and/or Glens Falls Integrated Delivery System (IDS) • Healthcare Partners of Saratoga (Malta Med) and/or Healthcare Partners Integrated Delivery System (IDS) • Saratoga Hospital Medical Group and/or Saratoga Hospital Medical Group Integrated Delivery System (IDS) • The Saratoga Hospital and/or The Saratoga Hospital Integrated Delivery System (IDS) • Other	Displays if Section II Q5 = Yes
6.	Describe your relationship with the Albany Med Health System:	Displays if Section II Q1 to Q5 all = No
Section III. Research		
1.	Are you listed on any funded or proposed research projects? Yes/No	
1a.	Have you received any support or significant financial interests from a foreign entity? Yes/No	Displays if Section III Q1 = Yes

1a1.	Identify the entity or entities and the country of origin for each in the space below. You will need to provide the details of this support within Section IV. Reporting potential Conflicts of Interest.	Displays if Section III Q1a = Yes
1b.	Are you a Principal Investigator of a research project? Yes/No	Displays if Section III Q1 = Yes
1b1.	The Principal Investigator is responsible for identifying all persons involved in the research projects they administer. Respond to the next set of questions to identify all persons involved, in whole or part, in the design, conduct or reporting of research activities or results where you are the Principal Investigator. Enter the following information for each research project: a. Enter Sponsor Information • Sponsor ID • Sponsor Name • Info Ed Tracking Number, if applicable b. Provide the name, role (check all that apply), and work email for all Individuals involved in the research project. c. Do you have *another* research project to report? *This set of questions repeat until all research projects have been reported. The online instrument allows for the entry of up to 5 research projects. A member of Corporate Compliance and Audit will follow-up with those Individuals who have identified more than 5 research projects.*	Displays if Section III Q1b = Yes
Section IV. Potential Conflicts of Interest		
1.	Have you or a related person: 1. Received a **GIFT** that could reasonably be attributed to your duties or position with the System beyond a nominal amount or specifically prohibited by the policy (COI Policy Appendix 4-a): Yes/No 2. Received **COMPENSATION** or other payment for services from other than a System entity that could reasonably appear to affect your actions on behalf of a System entity or entities: Yes/No 3. Been promised or have an **OWNERSHIP INTEREST** in an entity, assets, rights or other items of value; or the option to obtain an ownership interest that could reasonably be perceived as influencing actions or judgments made in the performance of your roles and responsibilities at the System: Yes/No 4. Been promised or received **OFFERS CONTINGENT** in whole or in part on actions or outcomes related to actions or judgments taken or planned on behalf of the System: Yes/No 5. Engaged in activity that would establish a **RELATIONSHIP** that could be perceived as creating a potential conflict of interest with	

	your actions or judgments on behalf of the System and the people we serve: Yes/No 6. Been promised or received any **OTHER** items or services of value that could be perceived as creating a potential conflict of interest with your duties and responsibilities at the System: Yes/No	
1a.	You need to provide the details for each potential COI identified in the previous question. Answer the next set of questions (identified as "Item 1") regarding the first potential COI identified. At the end of the question set, you will be asked if you have an additional item to report. Answer Yes to provide details for the next potential COI. This loop will continue until you've disclosed all potential COIs for yourself and related persons that was not previously disclosed. For each item identified in Section IV Question 1 the following questions will display: a. Potential COI Type (select best option): o Gift o Compensation o Ownership Interest o Contingent Offer o Relationship o Other b. Enter the Dates applicable: *open text field* c. Identify the name of the person or entity providing the item(s) or with whom the relationship exists: *open text field* d. Describe the details and circumstances related to the potential COI: *open text field* e. Estimate the Fair Market Value of the potential COI (if this is your primary means of employment select, "Primary employment"): o No or nominal value o Less than $1,000 o $1,000 to $4,999 o $5,000 to $9,999 o $10,000 to $24,999 o $25,000 to $49,999 o $50,000 to $100,000 o Greater than $100,000 o Primary employment o Unable to estimate, please contact me f. Identify the Related Persons Receiving the Item or with the Relationship (check all applicable): o A-Self o B-Spouse or domestic partner o C-Parents including in-laws o D-Dependent children o E-Siblings o F-Person living in the Individual's household	Displays if Section IV Q1 has Yes to any

	o G-Person dependent on the Individual for ongoing support o H-Person whom the Individual is dependent on for ongoing support o I-Children Independent for Income Tax reporting+ o J-Spouse of siblings, children, grandchildren, or great-grand-children+ o K-Grandchildren or great-grandchildren+ o L-Ancestors+ g. Are you or the Related Person a director, principal officer, member of a committee with governing board delegated powers, or a Key Employee of the identified entity? Yes/No (Question g displays only if Compensation, Ownership Interest, or Relationship is selected for question a, Potential COI Type) h. Do you have another potential COI to report? Yes/No +Applicable to Members of the Board, Individuals on committees with Board-delegated authority, Officers, Key Employees, and Other Interested Parties – refer to COI Policy Appendix 1, Definitions and Appendix 4-g, Excess Benefit Transactions. *This set of questions will repeat until all potential COIs have been reported. The online instrument allows for the entry of up to 8 potential COIs. A member of Corporate Compliance and Audit will follow-up with those Individuals who have identified more than 8 potential COIs.*	
Section V. Potential Related Party Transactions		
1.	Do you know of an existing or potential transaction in which a System entity is a participant and in which you or a Related Person have a conflict of Interest? • Yes, already reported in this disclosure • Yes, still need to report transaction • No	
1a.	Provide all material facts related to the transaction.	Displays if Section V Q1=Yes, still need to report transaction
Section VI. Certification		
1.	Are there any other events, relationships or interests that may create a potential Conflict of Interest for you or a Related Person that you have not disclosed in a preceding section of this form? Yes/No	
1a.	Describe the Other Events, Relationships, or Interest:	Displays if Section VI Q1 = Yes
2.	Is there any other information you want to provide as part of your Conflict of Interest disclosure? Yes/No	

2a.	Miscellaneous Comments:	Displays if Section VI Q2 = Yes
3.	I have read, understand and agree to comply with the Albany Med Health System Conflict of Interest (COI) Policy. I understand the System is comprised of charitable entities under IRS federal tax exemption and in order to maintain that exception, each entity must engage primarily in activities which accomplish one or more of its tax-exempt purposes. I agree to update my disclosure of potential Conflicts of Interest within 15 days of any material change. To the best of my knowledge and belief, the information provided in this Disclosure Form is an accurate and complete disclosure of all potential Conflict of Interests for myself and Related Persons as required by System policies and relevant government rules and regulations. I will provide, upon request, additional information and documentation to allow the timely administration of the COI Policy by authorized System representatives. I agree to work cooperatively with authorized System representatives to administer the COI Policy and abide by any conditions or restrictions deemed necessary by the System to manage, reduce, or eliminate actual or potential Conflicts of Interest. I have read, understand and agree to the representations above. ***Signature***	
4.	Date (mm/dd/yyyy) - If the month or day is less than two digits, you must enter a leading 0. Four-digit year is also required.	