



**HOLY CROSS HOSPITAL INSTITUTIONAL REVIEW BOARD**  
**FINANCIAL CONFLICT OF INTEREST SCREENING AND DISCLOSURE FORM**  
**(INVESTIGATOR)**

Individuals seeking permission from the Hospital's Institutional Review Board to conduct research on humans accept an obligation to avoid financial conflicts of interest in performing their research. The following questions are necessary to determine if a potential conflict of interest exists. **This form must be completed annually and updated as necessary by all persons seeking to conduct research on humans at the Hospital. You are responsible for updating this information throughout the course of the study and for one year after completion of the study.**

Could your compensation be affected by the study outcome? YES \_\_\_\_ NO \_\_\_\_

Do you have a proprietary interest (such as a patent, trademark, copyright, or licensing agreement) in the tested product? YES \_\_\_\_ NO \_\_\_\_

Do you have any equity interest in the sponsor of the study (such as any ownership interest, stock options, or other financial interest)? YES \_\_\_\_ NO \_\_\_\_

Do you have an equity interest in any publicly-held company that exceeds \$50,000 in value, the value of which may be subject to fluctuation based on the outcome of this study? (Exclude equity interests in mutual funds.)  
YES \_\_\_\_ NO \_\_\_\_

Will you receive payments (including retainer for ongoing consultation, salary, gifts, donations, grants, equipment) from the sponsor that have a cumulative monetary value of \$25,000? In answering this question, exclude payments covering the cost of this or other studies.  
YES \_\_\_\_ NO \_\_\_\_

Do you have a managerial role in any outside entity whose financial interests may be affected by this research?  
YES \_\_\_\_ NO \_\_\_\_

Does any member of your immediate family have any opportunity for financial gain based on the outcome of the study or related to your area of research? YES \_\_\_\_ NO \_\_\_\_

**If you answered "Yes" to any question, please attach details.**

I affirm that the above information is true and complete to the best of my knowledge. I accept responsibility for complying with all Hospital policies regarding financial conflicts of interest. I accept responsibility for updating this form annually and as necessary if my answers to the above questions should change. In my good faith professional judgment, I have no financial conflict of interest with regard to the research I wish to conduct at the Hospital, except as otherwise indicated on this form.

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

NAME (PRINT): \_\_\_\_\_

Protocol Title: \_\_\_\_\_

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