Regional Physician Network

Conflict of Interest Disclosures

Name: ___________________________________ **Date**: ________________________

Relationship to the RPN (name of practice group): ____

If you indicated on the Annual Attestation that you have an *interest* as defined by the Conflict of Interest Policy, please complete this document with as much information as possible about each *interest*. Please attach any additional information you believe the Compliance Committee should have in order to understand your disclosure.

Name of Entity	Reporting for Family or Self	Relationship with Entity	Managerial/Board role? (if yes, list role)	Type and amount of compensation received/ value of equity interest

I have read and understand the RNP's Conflict of Interest Policy and have completed this Disclosure Form to the best of my knowledge. If required, I will comply with any conditions or restrictions imposed by the Compliance Committee in order to continue my participation in the RPN. Should there be a material change in any of my *interests* that would result in different answers on this form, I agree to update my disclosures.

____ ____

Signature **Date of Review by Compliance Committee**