

**GENESYS REGIONAL MEDICAL CENTER
INSTITUTIONAL REVIEW BOARD**

Disclosure of Potential Financial Conflict of Interest

ONE SIGNED COPY IS NEEDED FOR EACH PRINCIPAL AND SUBINVESTIGATOR

Study Title:

Study Sponsor:

Certificate of Financial Disclosure

Please complete all of the information below and retain a copy for your records

Clinical Investigator/Sub-investigator Name: _____

Institution Name (if applicable): _____

Address: _____

Please check appropriate box:

Primary Investigator

Sub-Investigator

I certify that any affiliation with, or involvement in, any organization or entity with at direct financial interest in the subject matter or materials discussed in this proposal (e.g. employment, consultancies, stock ownership, honoraria, expert testimony) are disclosed below.

Conflict of Interest Signature:

No, I do not have a conflict of interest

Yes, I do have a potential conflict of interest

Signature _____

Date: _____