Allina Health System
Office of Sponsored Programs
2925 Chicago Avenue, MC 10105
Minneapolis, MN 55440-0043
OSP@allina.com

SUBRECIPIENT FINANCIAL CONFLICT OF INTEREST DISCLOSURE FORM – AWARD

The United States Public Health Service (PHS) Financial Conflict of Interest (FCOI) policy (effective August 24, 2012) mandates that Allina Health determine if a subrecipient has a PHS-compliant FCOI policy, and also requires the subrecipient to disclose certain information should a FCOI be present.

Allina Health will collect this information prior to issuing a subaward agreement, and then annually at the time of renewal.

Subrecipient Information

Subrecipient Legal Name: _____

PI name: _____

PI email address: _____

PI phone number: _____

FCOI contact information (if different from PI):

_____

Institutional Financial Conflict of Interest Information

☐ My organization **DOES HAVE** a PHS-compliant Financial Conflict of Interest (FCOI) policy and my organization will rely on this policy and associated procedures to comply with PHS Conflict of Interest regulation.

____ **Yes or** ___ **No:** We are registered as an organization with a PHS-compliant FCOI policy with the FDP.
Clearinghouse: http://sites.nationalacademies.org/PGA/fdp/PGA_070596.

☐ My organization **DOES NOT HAVE** a PHS-compliant Financial Conflict of Interest (FCOI) policy.

____ **Yes or** ___ **No:** My organization agrees to rely on Allina Health's Research and Sponosred Programs Conflict of Interest policy and procedures to comply with PHS Conflict of Interest regulations.
Note: Organizations checking this option are required to follow Allina Health's COI and FCOI policies and procedures.

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Project Specific Financial Conflict of Interest Information

Title of Proposal: _____

_____ **NO -** conflicts of interest need to be disclosed at this time.

_____ **YES -** there are conflicts of interest to be disclosed. **For each of the investigators on this project with a positive FCOI, please included the data requirements listed on page 2**.

Signature

Signature of Subrecipient's Authorized Official: _____

Date: _____

Name of Authorized Official: _____

Title: _____

SUBRECIPIENT FCOI DISCLOSURE FORM

If there is a positive FCOI, please complete the following data requirements:

Grant number: _____

PD/PI or contact PD/PI: _____

Name of Investigator with the FCOI: _____

Name of the entity(s) with which the Investigator has an FCOI

Nature of FCOI (e.g., equity, consulting fees, travel reimbursement, honoraria)
Value

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Value of the financial interest $0-$4,999; $5,000-$9,999; $10,000-$19,999; amounts between $20,000-$100,000 by increments of $20,000; amounts above $100,000 by increments of $50,000, or a statement that a value cannot be readily determined.

Provide a description how the financial interest relates to NIH-funded research and the basis for the Institution’s determination that the financial interest conflicts with such research.

Provide the key elements of the Institution’s management plan.