SUBRECIPIENT FCOI DISCLOSURE FORM - AWARD

The United States Public Health Service (PHS) Financial Conflict of Interest (FCOI) policy (effective August 24, 2012) mandates that the Duke University determine if a subrecipient has a PHS-compliant FCOI policy, and also requires the subrecipient to disclose certain information should a FCOI be present. Duke University will collect this information prior to issuing a subagreement, 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  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  No  My organization agrees to rely on Duke University’s FCOI policy and procedures to comply with PHS Conflict of Interest regulations.

Note: Organizations checking this option are required to follow Duke’s COI and FCOI policies: https://medschool.duke.edu/sites/default/files/field/attachments/FCOI-May-2011-1.pdf

**Project Specific FCOI Information (Only required if using your organization’s FCOI policy)**

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: _________________________
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 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.