DUKE UNIVERSITY
Office of Research Administration

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: http://medschool.duke.edu/files/FCOI-May-2011.pdf.

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: ________________________

For internal use only: SPS number:_______________ Agency ID: ________________________

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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.