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Questionnaire for Physicians to Help Identify Conflicts of Interest with Vendors

By Nina Youngstrom

Pomona Valley Hospital Medical Center in California uses this checklist to ask physicians about compensation and other financial relationships with vendors they have that could create a conflict of interest. Contact Compliance Officer Kathy Perkins at kathy.perkins@pvhmc.org.

Physician Questionnaire

Physician name: _____

For purposes of answering these questions, the following definitions apply:

“Immediate family member” means the following individuals: husband or wife; birth or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-in-law, son-in-law, daughter-in-law or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

“Compensation” means any acceptance of gifts, gratuities, payments, loans or other consideration of any kind, from supplier of products or services or any other entity doing, or seeking to do, business with the hospital. For the purposes of this policy, gifts shall be considered any item or items with a value exceeding \$25.

“Financial interest” means direct or indirect financial or other interest in, or relationships with, any supplier or other entity which has a business, financial or other relationship with the hospital, other than ownership of less than 1% of the outstanding shares of an entity whose shares are publicly traded.

“Company/vendor” means a product manufacturer, distributor or service provider for healthcare product and services.

1. Do you or a member of your family have a family or business relationship with the **company** that offers the supplies/equipment requested.
☐ No ☐ Yes
 2. Do you own in whole or part, directly or indirectly, any part of the **company** that offers the supplies/equipment requested?
☐ No ☐ Yes
 3. Are you involved with any other matter that could be perceived as a **conflict of interest** with the company or vendor that offers the supplies/equipment requested?
☐ No ☐ Yes
 4. Do you receive **compensation** from the company or vendor that offers the supplies/equipment requested?
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☐ No ☐ Yes

5. Do you own stock in any publicly-traded healthcare related company (eg., medical manufacturer, pharmaceutical company, laboratory company)? Please provide this information to help ensure our compliance with a new regulatory requirement?

☐ No ☐ Yes

If you answered "Yes" to any of the questions (1-5) above, please indicate whether the physician/person is an owner, an employee or a contractor of the company and complete the following:

(a) List the name of the person or entity involved (e.g., employee name, family member name, related business interest name).: _____

(b) Describe the employment, service or ownership interest _____

(c) If applicable, the name of the person, who have ownership in the company

I represent that the answers provided herein are truthful and accurate as of the date of my signature below. I agree to immediately notify Pomona Valley Hospital Medical Center of any changes in the above disclosed information.

PHYSICIAN SIGNATURE _____

DATE _____

PRINT NAME _____

TITLE _____

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