



**TAHOE FOREST
HOSPITAL DISTRICT**

POLICY/PROCEDURE

NO. _____

SECTION MEDICAL STAFF

**TITLE: EXECUTIVE COMMITTEE REQUIREMENT:
COMPLETE DISCLOSURE FORM**

P.O. Box 759 Truckee, CA 96160 (530) 587-6011
880 Alder Ave. Incline Village, NV 89451 (775) 832-3810

POLICY

Each year, all elected Medical Executive Committee members must complete a disclosure form regarding potential conflicts of interest to disclose any financial or other relationships or arrangements that the physician has with the hospital and its affiliates or with any organizations with which the hospital does business or competes. Such disclosures are required to ensure compliance with anti-kickback, Stark, and other federal and state laws and regulations and to avoid potential conflicts of interest in governing the hospital's operations.

Medical Executive Committee members are to notify the medical staff of changes when they occur.

Disclosure form to be retained in the member's credentials file in the Medical Staff Office.

FORMULATED BY:
Terri Schnieder, CPMSM, Director of Medical Staff Services

EFFECTIVE DATE: 1/12/2006

ADMINISTRATIVE APPROVAL:

DATE REVISED:

APPROVAL:
Chief of Staff 1/11/2006

DATE REVIEWED: 1/11/2006 ; 2/2007– Executive Committee



TAHOE FOREST HOSPITAL DISTRICT

POLICY/PROCEDURE

NO. _____

SECTION MEDICAL STAFF

TITLE: EXECUTIVE COMMITTEE REQUIREMENT:
COMPLETE DISCLOSURE FORM

P.O. Box 759 Truckee, CA 96160 (530) 587-6011
880 Alder Ave. Incline Village, NV 89451 (775) 832-3810

DISCLOSURE FORM

All Medical Executive Committee members must answer the questions below to disclose any financial or other relationships or arrangements that the physician has with the hospital and its affiliates or with any organizations with which the hospital does business or competes. Such disclosures are required to ensure compliance with anti-kickback, Stark, and other federal and state laws and regulations and to avoid potential conflicts of interest in governing the hospital's operations.

PLEASE COMPLETE QUESTIONNAIRE BELOW AND RETURN TO THE MEDICAL STAFF OFFICE FOR RETAINING IN YOUR CREDENTIALS FILE:

1. Are there any financial arrangements between the hospital and any of its affiliates and you or a member of your family, or the physician group or other entity in which you practice medicine?

_____ Yes _____ No If yes, please describe: _____

2. Do you, a family member or your physician group or employer have any current or past financial or other relationships with suppliers, pharmaceutical companies, durable medical equipment suppliers, and other vendors (Including ownership or investment interest, loans, employment or other compensation arrangements)?

_____ YES _____ NO If yes, please describe: _____

3. Are you the member of the board of directors or do you have any ownership or other interest in or relationship with entities that provide healthcare services (e.g., ambulatory surgical centers or physician practices), including employment or other compensation arrangement but excluding less than 1% stock ownership of publicly traded companies?

_____ YES _____ NO If yes, please describe: _____

4. Are there any outstanding loans between you or a family member or your physician group or employer and the hospital or an affiliate or any organization that does businesses with or competes with the hospital or its affiliates?

_____ YES _____ NO If yes, please describe: _____

5. Have you, a family member, or your physician group or other employer received any gifts, entertainment, or other benefits from any organization doing business with or seeking to do business with the hospital. (E.g., gifts and entertainment received from pharmaceutical companies)?

_____ YES _____ NO If yes, please describe: _____

6. Please identify any other interests in, relationships with, or benefits received from any entity that could influence decision-making on behalf of the hospital: _____

FORMULATED BY:
Terri Schnieder, CPMSM, Director of Medical Staff Services

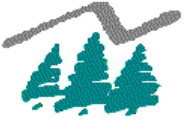
EFFECTIVE DATE: 1/12/2006

ADMINISTRATIVE APPROVAL:

DATE REVISED:

APPROVAL:
Chief of Staff 1/11/2006

DATE REVIEWED: 1/11/2006 ; 2/2007- Executive Committee



**TAHOE FOREST
HOSPITAL DISTRICT**

POLICY/PROCEDURE

NO. _____

SECTION MEDICAL STAFF

**TITLE: EXECUTIVE COMMITTEE REQUIREMENT:
COMPLETE DISCLOSURE FORM**

**P.O. Box 759 Truckee, CA 96160 (530) 587-6011
880 Alder Ave. Incline Village, NV 89451 (775) 832-3810**

The answers to the above questions are true and accurate to the best of my knowledge, and I will inform the medical staff office of any changes to these answers that may occur in the following year.

NAME: _____ / _____
(Signature) (Print)

POSITION: _____ DATE: _____

FORMULATED BY:
Terri Schnieder, CPMSM, Director of Medical Staff Services

EFFECTIVE DATE: 1/12/2006

ADMINISTRATIVE APPROVAL:

DATE REVISED:

APPROVAL:
Chief of Staff 1/11/2006

DATE REVIEWED: 1/11/2006 ; 2/2007– Executive Committee