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Questionnaire for Vendors to Help Identify Conflicts of Interest

By Nina Youngstrom

Pomona Valley Hospital Medical Center in California uses this checklist to ask vendors to disclose any relationship they may have that could create a conflict of interest with an ordering provider or any employee. Contact Compliance Officer Kathy Perkins at kathy.perkins@pvhmc.org.

Conflict of Interest

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

"**Family relative**" 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.

#	Category	Requirements	COMMENTS & EXPLANATION	Vendor agrees	
				Y	N
F.1	Company	Does your company have a current business relationship with PVHMC? Please identify those supplies/services or equipment.			
F.2	Ownership	Does your company, in whole or part, directly or indirectly, own any part of a company or division that currently has a business contract with PVHMC? (not mentioned above)			
F.3	Involvement	Is your company, or any affiliated company, involved with any other matter that could be perceived as a conflict of interest with PVHMC?			
F.4	Compensation	What is the approximate compensation paid by PVHMC to the companies listed in F.1, F.2 or F.3?			

F.5	Family relationships	Does any member of your company have a family relative who works at PVHMC? Please provide name and title of both your employee and ours, and their relationship.			
F.6	Stock	Does your company own stock in any publicly traded healthcare-related company (e.g., medical manufacturer, pharmaceutical company, laboratory company)?			

Please provide this information to help ensure our compliance with the new regulatory requirement. 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.

Name: _____

Title: _____

Signature: _____

Date: _____