

**COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES  
 PHARMACY AND THERAPEUTICS COMMITTEE  
 CONFLICT OF INTEREST DISCLOSURE STATEMENT FORM**

As a healthcare provider that participates in a DHS pharmaceutical formulary committee, or is submitting a request for formulary review, you are required to disclose pharmaceutical vendor/manufacture conflicts of interest that may exist.

<b>Name</b> (please print):			
<b>Title:</b>			
<b>Department:</b>		<b>Contact telephone number:</b>	
<b>Email address:</b>			
<b>DHS Facility:</b>	<input type="checkbox"/> EI Monte CHC	<input type="checkbox"/> Humphrey CHC	<input type="checkbox"/> OV/UCLA MC
<input type="checkbox"/> LAC+USC MC	<input type="checkbox"/> H/UCLA MC	<input type="checkbox"/> MLK MACC	<input type="checkbox"/> Mid-Valley CHC
<input type="checkbox"/> Hudson CHC	<input type="checkbox"/> Long Beach CHC	<input type="checkbox"/> High Desert MACC	<input type="checkbox"/> San Fernando CHC
<input type="checkbox"/> Roybal CHC	<input type="checkbox"/> Wilmington CHC	<input type="checkbox"/> Rancho LA NRC	<input type="checkbox"/> Other: _____
<b>Reason for Disclosure:</b>			
<b>I am completing this disclosure form for the following committee and/or purpose: (Check all that apply)</b>			
<input type="checkbox"/> Submitting Drug Request to be reviewed by DHS Core P&T Committee			
<input type="checkbox"/> DHS Core Pharmacy & Therapeutics Committee			
<input type="checkbox"/> DHS Facility Pharmacy & Therapeutics Committee			
<input type="checkbox"/> DHS Expert Panel (List): _____			
<b>Disclosure Statement:</b>			
<b>I have read and understand the Los Angeles County DHS Conflict of Interest Disclosure Policy- Pharmaceutical, and hereby disclose the following (Please check one of the following):</b>			
<input type="checkbox"/> I have "NO" conflicts of interest to disclose. (Please sign the form on the last page)			
<input type="checkbox"/> I do have existing conflicts of interest, either currently or within the last 12 months.			

**The following is a list of my potential conflicts of interest (Check all that apply).**

I or my immediate family (i.e., spouse/domestic partner or dependents) have/has been a member of the Board of Directors or Advisory Board for a pharmaceutical vendor/manufacture within the past 12 months.

Pharmaceutical Vendor / Manufacturer	Position Held (category 1 conflict)

I or my immediate family (i.e., spouse/domestic partner or dependents) have/has been appointed to a pharmaceutical company sponsored Speaker's Bureau (defined as more than one lecture affiliated with the same company in the past 12 months).

Pharmaceutical Vendor / Manufacturer	Specific Drug / Agent (category 1 conflict)

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I or my immediate family (i.e., spouse/domestic partner or dependents) have/has been an author of company-sponsored publications, including books and periodicals without direct monetary payment.

Pharmaceutical Vendor / Manufacturer	Publication Title (category 2 conflict)

I or my immediate family (i.e., spouse/domestic partner or dependents) have/has received income, including but not limited to income from direct employment, speaking on behalf of a pharmaceutical vendor/manufacturer, or consulting activities from a pharmaceutical vendor/manufacturer.

Pharmaceutical Vendor / Manufacturer	Position Held	Amount Received >\$1,000 (category 1 conflict)	Amount Received >\$99 (category 2 conflict)

I or my immediate family (i.e., spouse/domestic partner or dependents) have/has personal financial holdings in the form of stocks (excluding mutual funds) or royalties affiliated with pharmaceutical companies.

Pharmaceutical Vendor / Manufacturer	Specify Financial Holdings Type	Valuation Amount >\$1,000 (category 1 conflict)	Valuation Amount >\$99 (category 2 conflict)

I or my immediate family (i.e., spouse/domestic partner or dependents) have/has received pharmaceutical vendor/manufacturer research funding (NOT income to the individual). For Phase I, II, or III research, the DHS Core P&T Committee has discretion to review the relevance of conflict as it pertains to participation in discussion or voting. Phase IV research is considered a conflict in the aforementioned funding amounts.

Pharmaceutical Vendor / Manufacturer	Specific Drug / Agent	List Trial Phase (i.e., I, II, III, or IV)	Amount Received >\$49,999 (category 1 conflict)	Amount Received >\$9,999 (category 2 conflict)

I or my immediate family (i.e., spouse/domestic partner or dependents) have/has received pharmaceutical vendor/manufacturer educational grants, scholarships, or awards, including funds by a third party.

Pharmaceutical Vendor / Manufacturer	Grant of Contract Title (include specific agent)	Amount Received >\$1,000 (category 1 conflict)	Amount Received >\$99 (category 2 conflict)

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I or my immediate family (i.e., spouse/domestic partner or dependents) have/has received income from a non-pharmaceutical vendor/manufacturer as a result of presenting continuing education, professional speaker fees, or contracted education programs that focused on a specific drug or drug class. The DHS Core P&T Committee has discretion to review relevance of conflict.

List Topic of Speaking Engagement	Name of Drug or Therapeutic Class Involved	Amount Received >\$1,000 (category 1 conflict)	Amount Received >\$99 (category 2 conflict)

I or my immediate family (i.e., spouse/domestic partner or dependents) have/has received personal gifts, meals, pens, honoraria, compensation or rewards from pharmaceutical companies in the past 12 months.

Pharmaceutical Vendor / Manufacturer	Type	Amount Received >\$1,000 (category 1 conflict)	Amount Received >\$99 (category 2 conflict)

I or my immediate family (i.e., spouse/domestic partner or dependents) have/has been involved in any **other** potential conflict of interest as defined below:

Pharmaceutical Vendor / Manufacturer	Description

I have reviewed "DHS Conflict of Interest Disclosure Policy-Pharmaceutical" and have submitted all of my known disclosures, as stipulated in this policy. I understand that it is my obligation to fully disclose all potential conflicts of interest. If my conflicts of interests change, or if I become aware of any additional potential conflicts, I understand that is my responsibility to submit an updated disclosure form to the DHS Core Pharmacy & Therapeutics Committee.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please return the completed form to:

DHS Pharmacy Affairs  
 313 N. Figueroa Street, Suite 701  
 Los Angeles, CA 90012

You may fax form to:

Attention: DHS Pharmacy Affairs  
 (213) 975 - 9623

Approved by:

DHS Core P&T Committee

Effective Date: 1/14/14

Last Updated: 1/14/14