METROPOLITAN WASHINGTON REGIONAL HIV HEALTH SERVICES PLANNING COUNCIL

CONFLICT OF INTEREST DISCLOSURE FORM

Please complete this form and return it to Chairperson, Metropolitan Washington Regional HIV Health Services Planning Council, *c/o Planning Council Coordinator, DC HIV/AIDS Administration, 64 New York Avenue, NE, Suite 500, Washington, DC 20002. Telephone: (202) 671-4900.*

I _____ hereby affirm that I have received, read, accept and will comply with the current Conflict of Interest Policy and Procedures adopted by the Metropolitan Washington Regional HIV Health Services Planning Council and approved by the Office of Boards and Commissions in the Executive Office of the Mayor of the District of Columbia, CEO of the EMA. If my affiliation changes, I will complete and file an updated Conflict of Interest Disclosure Form within thirty (30) days of the effective date of the change.

DECLARATION OF AFFILIATIONS POSING POSSIBLE CONFLICT OF INTEREST

I and/or a family member am/are affiliated with the following organization(s) applying for or receiving funds authorized under Part A of the Ryan White Treatment Modernization Act of 2006

Organization Name: _____ Position: _____

Name: _____ Relationship to Member: _____

Ryan White Service Categories: _____

_____

Organization Name: _____ Position: _____

Name: _____ Relationship to Member: _____

Ryan White Service Categories: _____

_____

Organization Name: _____ Position: _____

Name: _____ Relationship to Member: _____

Ryan White Service Categories: _____

_____

Signature: _____

Printed Name: _____ **Date:** _____