MEMORIAL HOSPITAL OF RHODE ISLAND

BROWN Alpert Medical School

Form for Non-Memorial Hospital of Rhode Island
Certification by Investigators Participating in Memorial Hospital of Rhode Island Proposals

for PHS Funding (or Other Agencies that follow PHS Guidelines)

Part I
Investigator/Subrecipient PI Name: Investigator Institution (if applicable):_____

Memorial Hospital of Rhode Island PI: _____

Project Title: _____

A. ☐ Subrecipient Organization/Institution certifies that ***it has or agrees to establish*** an active and enforced Financial Conflict of Interest (FCOI) policy that is consistent with the provisions of 2011 Revised FCOI regulations – "Responsibility of Applicants for Promoting Objectivity in Research for which PHS Funding is Sought (42 CFR Part 50, Subpart F) and Responsible Prospective Contractors (45 CFR Part 94)". Subrecipient also certifies that, to the best of its knowledge, (1) all financial disclosures have been made related to the activities that may be funded by or through a resultant agreement, and required by its FCOI policy; and, (2) all identified conflicts of interest have or will have been satisfactorily managed, reduced or eliminated in accordance with subrecipient's FCOI policy prior to the expenditures of any funds under a resultant agreement.

Tools are available on the NIH web site to assist institutions with policy development process, including a Checklist at: http://grants.nih.gov/grants/policy/coi/checklist_policy_dev_20120412.pdf and a FCOI tutorial at: http://grants.nih.gov/grants/policy/coi/tutorial2011/fcoi.htm. You may also reference the guidance documents at http://sites.nationalacademies.org/PGA/fdp/PGA_061001.

B*. ☐ Subrecipient does not have an active and enforced Financial Conflict of Interest policy ***and agrees to abide by Memorial Hospital of Rhode Island's policy***, located online at: http://www.mhri.org/ss_files/downloads/conflict_of_interest__phs_funded_researchdec_2012.pdf

Authorized Institutional Official Signature: _____

Date: _____

Printed Name: _____

***If Box B is checked, complete Part II:**
Part II

Enter names of individuals working on this project who are **responsible for** design, conduct, or reporting of the research.
Subrecipient PI:

Investigator:

Investigator:

Investigator:

Please have each named Investigator complete and sign the attached page, making copies as necessary. Completed forms must be filed with Memorial Hospital of Rhode Island's Grants Accountant/Administration before proposal is submitted to the sponsor.

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Investigator Certification:

1. Do you have a Significant Financial Interest* related to your professional expertise or institutional responsibilities? No ____ Yes _____ if Yes, please explain:

2. Do you have a Significant Financial Interest that is related to this project? No ____ Yes _____ if Yes, please explain:

*Definition may be found at http://grants.nih.gov/grants/policy/coi/coi_faqs.htm#3169 , section D, item 8.

I certify that the information contained in this proposal application is true, complete, and accurate to the best of my knowledge and belief and that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.

Investigator Signature: _____

Date: _____

Printed Name: _____