

MOORE COUNTY HOSPITAL DISTRICT
CONFLICT OF INTEREST ACKNOWLEDGMENT

NAME: _____

HOME ADDRESS: _____

ASSOCIATION WITH MOORE COUNTY HOSPITAL DISTRICT:

POTENTIAL CONFLICTS OF INTEREST:

BEFORE COMPLETING THIS ACKNOWLEDGMENT:

This Acknowledgment should be completed only after a careful reading of the Conflicts of Interest Policy. Your response covers the period January 1, 20__ (or the day you became associated with the _____ Hospital if subsequent to this date) through the end of this calendar year 20__.

MAIL OR RETURN TO:

Secretary, Board of Directors

ACKNOWLEDGMENT

I have received a copy of the Moore County Hospital District's Conflict of Interest Policy dated _____. I have read and understand this policy and agree to comply with the Conflict of Interest Policy.

SIGNATURE: _____

DATE _____