Florida HIV/AIDS Comprehensive Planning Network
Conflict of Interest Disclosure Form

The Florida HIV/AIDS Comprehensive Planning Network has members who are professionally or personally affiliated with organizations that have, or might in the future request or recieve funds for HIV/AIDS prevention or patient care activities or services. Because of this potential conflict of interest, this disclosure form has been adopted by the Florida HIV/AIDS Comprehensive Planning Network and approved by the Florida Department of Health, Bureau of HIV/AIDS and must be completed by all current members in accordance with the bylaws of the Planning Group.

By my signature below, I certify that:

1. I have read, understand and support the Planning Group's bylaws and have received, read, understand and support the Conflict of Interest Policy and Procedures Statement.

2. Listed below are organizations with which I am presently affiliated.

Organization:____

Title:______________________________ Period of Affiliation:________________________

Organization:____

Title:______________________________ Period of Affiliation:________________________

Organization:____

Title:______________________________ Period of Affiliation:________________________

Organization:____

Title:______________________________ Period of Affiliation:________________________

(Please attach additional pages if necessary.)

3. The following is true to the best of my knowledge and ability:

Neither I nor my immediate family has received or intends to receive any gratuities, favors, or anything of material value by a representative of a community based organization that might alter my ability to work objectively in the community planning process.

Planning Group Member:___________________________________

Member Signature:____

Date:_______________________