Conflict of Interest Disclosure Form for Patient Programs

☐ First declaration ☐ Re-declaration

Personal Information

First Name		Last Name	
Email address		Telephone	
Clinic		Medical Registration Number	

As a treating physician/staff engaged to _____(PSP name), I agree to diligently disclose my intention and decision to enroll self, family member or relative into the program.

Declaration

☐ I have nothing to disclose according to the above statement on Conflict of Interest.
☐ I must disclose a Conflict of Interest as per the above statement.
☐ I confirm that my patient has provided her/his consent for purpose of disclosing sensitive personal data (if any, within this Conflict of Interest Disclosure Form) and acknowledges that such consent has been provided on her/his voluntary basis.

(Please fill in the below information):

I herewith disclose the following:

First Name of Patient		Last Name of Patient	
Last 3 digits of Patient's IC number		Relationship to you	

_____ _____

Name & Signature Date

For DKSH internal assessment:

Comments (if any):

_____ _____

PSP Ops Lead/Country Lead - Name & Signature Date