

Conflict of Interest Disclosure Form
Allied Health Department | Mineral Area College

Name: _____

MAC ID: _____

The purpose of this form is for you to disclose any interest or affiliations that you or a family member may have, when considered in light of your position as a Student Nurse within or relationship to the Allied Health Department, Mineral Area College, or any of its cooperative partners and facilities, governing bodies or funding sources may potentially create a conflict of interest. Review *II. General Guidelines 10. Conflict of Interest*.

Please disclose your interests and affiliations with the Allied Health Department, Mineral Area College or any of its cooperative partners and facilities, governing bodies or funding sources.

- I do not have any conflicts of interest with Mineral Area College. Neither do any family members.
- I do have a conflict of interest or a family member does.
- I may have a conflict of interest or a family member may. I am not sure.

Please describe the actual or potential conflict of interest(s) below:

Student Printed Name: _____

Student Signature: _____

Date Submitted: _____

*Actual and potential conflicts of interest will be reviewed by the Director of the Allied Health Department.
Any further action or requirements for the nursing student will be given in writing.*