



Patient's Right to Pharmacy Choice Commission Confidentiality and Conflict of Interest Disclosure Form

Confidentiality

As a member of the Patient's Right to Pharmacy Choice Commission, herein after "Commission" and serving as a hearing examiner for the Oklahoma Insurance Department (OID), I recognize that I will be privy to information that is confidential pursuant to statute or confidential proprietary information. All confidential information that I become aware of due to my association with the Commission and/or serving in my capacity as a hearing examiner will be treated with strict confidentiality. Except to the extent allowed or required by law, neither the contents nor the existence of this information or documentation will be shared with anyone other than the other members of the Commission and the Insurance Commissioner or his/her designee. I will direct any questions regarding my confidentiality obligations to the Oklahoma Insurance Department's Legal Division.

Conflicts of Interest

This Conflict of Interest Form should indicate whether the nominee has an economic interest in, or acts as an officer or director of, any entity whose financial interests would reasonably appear to be affected by serving of the Commission. The nominee should disclose any personal, business, or volunteer affiliations that may give rise to a real or apparent conflict of interest. Individuals with a conflict of interest should refrain from serving on the Commission.

A conflict of interest may not be real or apparent for the overall purpose of serving on the Commission, but may arise from time to time as the Commission reviews or hears specific



matters. Should a conflict of interest become real or apparent at that time, the individual must recuse himself or herself from discussing or hearing the matter or viewing any information regarding the matter except that which is available to the general public.

Please describe below any relationships, transactions, or positions you hold (volunteer or otherwise), or circumstances that you believe could contribute to or may pose a conflict of interest for you as a member of the Commission. You may attach additional documentation as needed.

_____ I have no conflict of interest to report.

_____ I have the following conflict(s) of interest to report:

1. _____;
2. _____;
3. _____;
4. _____.

I have read the conflicts of interest policy set forth above and agree to comply fully with its terms and conditions at all times during my service as a member of the Patient’s Right to Pharmacy Choice Commission. If at any time following the submission of this form I become aware of any actual or potential conflicts of interest, or if the information provided above becomes inaccurate or incomplete, I will promptly notify the Oklahoma Insurance Commissioner in writing.

Appointee Signature: _____ Date: _____

Appointee Name: _____

Appointee Position: _____