

MEDICAL ADVISORY BOARD MEMBER AGREEMENT

Produced by the National Organization for Rare Disorders (NORD®)

AFFIRMATIONS:

I hereby affirm the following:

I have received a copy of the [ORGANIZATION NAME]

Conflict of Interest policy. _____ (initial)

I have read and understand the policy. _____ (initial)

I agree to comply with the policy. _____ (initial)

I understand that [ORGANIZATION NAME] is a charitable organization and that in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more of its stated tax-exempt purposes. _____ (initial)

DISCLOSURES:

1. Do you have any material financial interest (current or potential), including any compensation arrangement, as defined in the [ORGANIZATION NAME] Conflict of Interest policy?

Yes No

- a. If yes, please describe this material financial interest:

- b. If yes, has the financial interest been disclosed, as provided in the [ORGANIZATION NAME] Conflict of Interest policy?

Yes No

2. In the past, have you ever had a material financial interest, including a compensation arrangement, as defined in the Conflict of Interest policy?

Yes No

- a. If yes, please describe this material financial interest, including when (approximately) this material financial interest occurred:

- b. If yes, has the financial interest been disclosed, as provided in [ORGANIZATION NAME] conflict of interest policy?

Yes No

3. Are you employed by or do you belong to an organization that takes public positions on policy issues affecting [ORGANIZATION NAME], the rare disease community or its interests?

a. If yes, please describe this policy interest:

b. If yes, has this policy interest been disclosed, as provided in the [ORGANIZATION NAME] conflict of interest policy?

Yes No

4. Please describe below any other relationships, positions or circumstances that you believe could constitute possible forms of conflict of interest not otherwise addressed above. If the answer is none, please write the word "none" below.

I hereby certify that the information set forth above is true and complete to the best of my knowledge. I have reviewed and agree to abide by the [ORGANIZATION NAME] policy on conflicts of interest in effect as of the date of signature of this document. By signing my name below, I certify that I have read, understand, and agree to the information and expectations outlined in the Medical Advisory Board Policies and Procedures for [ORGANIZATION NAME]. I understand that a violation of the Medical Advisory Board Policies and Procedures may result in consequent disciplinary action, including termination of my appointment on the Medical Advisory Board of or [ORGANIZATION NAME].

Name (Please Print)

Signature

Date (mm/dd/yyyy)