No Conflict

Program Representative Conflict of Interest Identification Form

Instructions: Each program representative is required to fill out this form individual and submit to his/her assigned Ombudsman Specialist. An ombudsman program representative is defined in APD 16-10-01, Office of the Long-Term Care Ombudsman, as employees or volunteers who are designated by the State Long-Term Care Ombudsman to perform the duties set forth in §1324.19(a).

Once this form has been completed, it will need to be re-named to identify the name of the individual program representative. ***For example Ollie Ombudsman lives in Sunny Hill County. Ollie's form would be titled "Ollie Ombudsman – Sunny Hill County – NO Conflict of Interest Identification Form".***

I, _____, PA Long-Term Care Ombudsman Program Representative, declare that I do not have a conflict of interest in the performance of my ombudsman duties as listed on the attached document. This has been disclosed to and verified by my ombudsman supervisor. I understand that should a conflict of interest arise, I will need to provide an updated Conflict of Interest Identification Form as soon as I become aware of the conflict of interest.

_____ _____

Signature of Program Representative Date