CLEAR

Sinai Health | Mount Sinai Hospital
Joseph & Wolf Lebovic Health Complex

NEW EMPLOYEE INFORMATION

EMPLOYEE INFORMATION:

Last Name: _____ **First Name:** _____

Date of Birth *(mm/dd/yyyy)*: _____ **Gender:** ☐ Male ☐ Female

Social Insurance Number *(please bring SIN to Orientation for verification)*: _____

Note: For employees with a SIN that begins with a "9" *– please provide HR with a copy of your work VISA*

Work Visa Expiry Date (mm/dd/yyyy): _____

Address: _____

City: _____ **Prov:** _____ **Postal Code:** _____

Home Phone Number: **Mobile Number:** _____

EMERGENCY CONTACTS:

Contact Name: _____ **Relationship:** _____

Home Number: _____ **Mobile Number:** _____

DIRECT DEPOSIT

PLEASE STAPLE YOUR VOID CHEQUE OR DIRECT DEPOSIT FORM HERE

HOOPP – Healthcare of Ontario Pension Plan

I have been advised that I am eligible to enrol in the Healthcare of Ontario Pension Plan as a new employee by Mount Sinai Hospital, I confirm that:

☐ I would like to enroll in HOOPP as of my hire date (an enrolment form will be provided at Orientation)

☐ I am electing not to enrol in HOOPP at this time.

I will not be making contributions to the plan, nor will my employer do so on my behalf; I will not be entitled to a pension or any other benefits from the plan with respect to my employment with this employer; I have the right to cancel this waiver and enrol in at any time on a go forward basis (not retroactive) by providing my employer with written notification of my intention to enrol and this waiver will no longer be effective, and I will be required to join the Plan, if I become a full-time employee with my employer.

Employee Signature: _____

Date *(mm/dd/yyyy):* _____

Canada Revenue Agency | Agence du revenu du Canada

2024 Personal Tax Credits Return

Protected B when completed

TD1

Read page 2 before filling out this form. Your employer or payer will use this form to determine the amount of your tax deductions.

Fill out this form based on the best estimate of your circumstances.

If you do not fill out this form, your tax deductions will only include the basic personal amount, estimated by your employer or payer based on the income they pay you.

Last name	First name and initial(s)	Date of birth (YYYY/MM/DD)	Employee number

Address	Postal code	**For non-residents only** Country of permanent residence	Social insurance number

1. Basic personal amount – Every resident of Canada can enter a basic personal amount of $15,705. However, if your net income from all sources will be greater than $173,205 and you enter $15,705, you may have an amount owing on your income tax and benefit return at the end of the tax year. If your income from all sources will be greater than $173,205 you have the option to calculate a partial claim. To do so, fill in the appropriate section of Form TD1-WS, Worksheet for the 2024 Personal Tax Credits Return, and enter the calculated amount here. **15,705**

2. Canada caregiver amount for infirm children under age 18 – Only one parent may claim $2,616 for each infirm child born in 2007 or later who lives with both parents throughout the year. If the child does not live with both parents throughout the year, the parent who has the right to claim the "Amount for an eligible dependant" on line 8 may also claim the Canada caregiver amount for the child.

3. Age amount – If you will be 65 or older on December 31, 2024, and your net income for the year from **all** sources will be $44,325 or less, enter $8,790. You may enter a partial amount if your net income for the year will be between $44,325 and $102,925. To calculate a partial amount, fill out the line 3 section of Form TD1-WS.

4. Pension income amount – If you will receive regular pension payments from a pension plan or fund (not including Canada Pension Plan, Quebec Pension Plan, old age security, or guaranteed income supplement payments), enter **whichever is less**: $2,000 or your estimated annual pension income.

5. Tuition (full-time and part-time) – Fill in this section if you are a student at a university or college, or an educational institution certified by Employment and Social Development Canada, and you will pay more than $100 per institution in tuition fees. Enter the total tuition fees that you will pay if you are a full-time or part-time student.

6. Disability amount – If you will claim the disability amount on your income tax and benefit return by using Form T2201, Disability Tax Credit Certificate, enter $9,872.

7. Spouse or common-law partner amount – Enter the difference between the amount on line 1 (line 1 plus $2,616 if your spouse or common-law partner is **infirm**) and your spouse's or common-law partner's estimated net income for the year if **two** of the following conditions apply:

- You are supporting your spouse or common-law partner who lives with you
- Your spouse or common-law partner's net income for the year will be less than the amount on line 1 (line 1 plus $2,616 if your spouse or common-law partner is **infirm**)

In all cases, go to line 9 if your spouse or common-law partner is **infirm** and has a net income for the year of $28,041 or less.

8. Amount for an eligible dependant – Enter the difference between the amount on line 1 (line 1 plus $2,616 if your eligible dependant is **infirm)** and your eligible dependant's estimated net income for the year if **all** of the following conditions apply:

- You do **not** have a spouse or common-law partner, or you **have** a spouse or common-law partner who does not live with you and who you are not supporting or being supported by
- You are supporting the dependant who is related to you and lives with you
- The dependant's net income for the year will be less than the amount on line 1 (line 1 plus $2,616 if your dependant is **infirm** and you **cannot** claim the **Canada caregiver amount for infirm children under 18 years of age** for this dependant**)**

In all cases, go to line 9 if your dependant is **18 years or older, infirm,** and has a net income for the year of $28,041 or less.

9. Canada caregiver amount for eligible dependant or spouse or common-law partner – Fill out this section if, at any time in the year, you support an **infirm** eligible dependant (aged 18 or older) **or** an **infirm** spouse or common-law partner whose net income for the year will be $28,041 or less. To calculate the amount you may enter here, fill out the line 9 section of Form TD1-WS.

10. Canada caregiver amount for dependant(s) age 18 or older – If, at any time in the year, you support an **infirm** dependant age 18 or older (**other than** the spouse or common-law partner or eligible dependant you claimed an amount for on line 9 or could have claimed an amount for if their net income were under $15,705) whose net income for the year will be $19,666 or less, enter $8,375. You may enter a partial amount if their net income for the year will be between $19,666 and $28,041. To calculate a partial amount, fill out the line 10 section of Form TD1-WS. This worksheet may also be used to calculate your part of the amount if you are sharing it with another caregiver who supports the same dependant. You may claim this amount for more than one infirm dependant age 18 or older.

11. Amounts transferred from your spouse or common-law partner – If your spouse or common-law partner will not use all of their age amount, pension income amount, tuition amount, or disability amount on their income tax and benefit return, enter the unused amount.

12. Amounts transferred from a dependant – If your dependant will not use all of their disability amount on their income tax and benefit return, enter the unused amount. If your or your spouse's or common-law partner's dependent child or grandchild will not use all of their tuition amount on their income tax and benefit return, enter the unused amount.

13. TOTAL CLAIM AMOUNT – Add lines 1 to 12.
Your employer or payer will use this amount to determine the amount of your tax deductions.

Canada

Filling out Form TD1

Fill out this form **only** if any of the following apply:

- you have a new employer or payer, and you will receive salary, wages, commissions, pensions, employment insurance benefits, or any other remuneration
- you want to change the amounts you previously claimed (for example, the number of your eligible dependants has changed)
- you want to claim the deduction for living in a prescribed zone
- you want to increase the amount of tax deducted at source

Sign and date it, and give it to your employer or payer.

More than one employer or payer at the same time

☐ If you have more than one employer or payer at the same time and you have already claimed personal tax credit amounts on another Form TD1 for 2024, you **cannot** claim them again. If your total income from all sources will be more than the personal tax credits you claimed on another Form TD1, check this box, enter "0" on Line 13 and do not fill in Lines 2 to 12.

Total income is less than the total claim amount

☐ Tick this box if your total income for the year from **all** employers and payers will be **less** than your total claim amount on line 13. Your employer or payer will not deduct tax from your earnings.

For non-resident only (Tick the box that applies to you.)

As a non-resident, will 90% or more of your world income be included in determining your taxable income earned in Canada in 2024?

☐ Yes (Fill out the previous page.)

☐ No (Enter "0" on line 13, and do not fill in lines 2 to 12 as you are not entitled to the personal tax credits.)

Call the international tax and non-resident enquiries line at **1-800-959-8281** if you are unsure of your residency status.

Provincial or territorial personal tax credits return

You also have to fill out a provincial or territorial TD1 form if your claim amount on line 13 is more than $15,000. Use the Form TD1 for your province or territory of **employment** if you are an employee. Use the Form TD1 for your province or territory of **residence** if you are a pensioner. Your employer or payer will use both this federal form and your most recent provincial or territorial Form TD1 to determine the amount of your tax deductions.

Your employer or payer will deduct provincial or territorial taxes after allowing the provincial or territorial basic personal amount if you are claiming the basic personal amount **only**.

Note: You may be able to claim the child amount on Form TD1SK, 2024 Saskatchewan Personal Tax Credits Return if you are a Saskatchewan resident supporting children under 18 at any time during 2024. Therefore, you may want to fill out Form TD1SK even if you are **only** claiming the basic personal amount on this form.

Deduction for living in a prescribed zone

You may claim **any** of the following amounts if you live in the Northwest Territories, Nunavut, Yukon, or another prescribed **northern** zone for more than six months in a row beginning or ending in 2024:

- $11.00 for each day that you live in the prescribed northern zone
- $22.00 for each day that you live in the prescribed northern zone if, during that time, you live in a dwelling that you maintain, and you are the only person living in that dwelling who is claiming this deduction

$ _____

Employees living in a prescribed **intermediate** zone may claim 50% of the total of the above amounts.
For more information, go to **canada.ca/taxes-northern-residents**.

Additional tax to be deducted

You may want to have more tax deducted from each payment if you receive other income such as non-employment income from CPP or QPP benefits, or old age security pension. You may have less tax to pay when you file your income tax and benefit return by doing this. Enter the additional tax amount you want deducted from each payment to choose this option. You may fill out a new Form TD1 to change this deduction later.

$ _____

Reduction in tax deductions

You may ask to have less tax deducted at source if you are eligible for deductions or non-refundable tax credits that are not listed on this form (for example, periodic contributions to a registered retirement savings plan (RRSP), child care or employment expenses, charitable donations, and tuition and education amounts carried forward from the previous year). To make this request, fill out Form T1213, Request to Reduce Tax Deductions at Source, to get a letter of authority from your tax services office. Give the letter of authority to your employer or payer. You do not need a letter of authority if your employer deducts RRSP contributions from your salary.

Forms and publications

To get our forms and publications, go to **canada.ca/cra-forms-publications** or call **1-800-959-5525**.

Personal information (including the SIN) is collected and used to administer or enforce the Income Tax Act and related programs and activities including administering tax, benefits, audit, compliance, and collection. The information collected may be disclosed to other federal, provincial, territorial, aboriginal or foreign government institutions to the extent authorized by law. Failure to provide this information may result in paying interest or penalties, or in other actions. Under the Privacy Act, individuals have a right of protection, access to and correction of their personal information, or to file a complaint with the Privacy Commissioner of Canada regarding the handling of their personal information. Refer to Personal Information Bank CRA PPU 120 on Information about Programs and Information Holdings at **canada.ca/cra-information-about-programs**.

Certification

I certify that the information given on this form is correct and complete.

Signature _____ Date _____

It is a serious offence to make a false return.

Ontario

2024 Ontario Personal Tax Credits Return

Protected B when completed
TD1ON

Read page 2 before filling out this form. Your employer or payer will use this form to determine the amount of your provincial tax deductions.

Fill out this form based on the best estimate of your circumstances.

Last name	First name and initial(s)	Date of birth (YYYY/MM/DD)	Employee number

Address	Postal code	**For non-residents only** Country of permanent residence	Social insurance number

1. Basic personal amount – Every person employed in Ontario and every pensioner residing in Ontario can claim this amount. If you will have more than one employer or payer at the same time in 2024, see "More than one employer or payer at the same time" on page 2. **12,399**

2. Age amount – If you will be 65 or older on December 31, 2024, and your net income will be $45,068 or less, enter $6,054. You may enter a partial amount if your net income for the year will be between $45,068 and $85,428. To calculate a partial amount, fill out the line 2 section of Form TD1ON-WS, Worksheet for the 2024 Ontario Personal Tax Credits Return.

3. Pension income amount – If you will receive regular pension payments from a pension plan or fund (not including Canada Pension Plan, Quebec Pension Plan, Old Age Security, or Guaranteed Income Supplement payments), enter **whichever is less**: $1,714 or your estimated annual pension.

4. Disability amount – If you will claim the disability amount on your income tax and benefit return by using Form T2201, Disability Tax Credit Certificate, enter $10,017**.**

5. Spouse or common-law partner amount – Enter $10,528 if you are supporting your spouse or common-law partner and **both** of the following conditions apply:

- Your spouse or common-law partner lives with you
- Your spouse or common-law partner's net income for the year will be $1,053 or less

You may enter a partial amount if your spouse's or common-law partner's net income for the year will be between $1,053 and $11,581. To calculate a partial amount, fill out the line 5 section of Form TD1ON-WS.

6. Amount for an eligible dependant – Enter $10,528 if you are supporting an eligible dependant and **all** of the following conditions apply:

- You do **not** have a spouse or common-law partner, or you **have** a spouse or common-law partner who does not live with you and who you are not supporting or being supported by
- The dependant is related to you and lives with you
- The dependant's net income for the year will be $1,053 or less

You may enter a partial amount if the eligible dependant's net income for the year will be between $1,053 and $11,581. To calculate a partial amount, fill out the line 6 section of Form TD1ON-WS.

7. Ontario caregiver amount – You may claim this amount if you are supporting an eligible infirm dependant aged 18 or older:

- your child or your grandchild (or your spouse or common-law partner);
- your parent, grandparent, brother, sister, aunt, uncle, niece or nephew who is resident in Canada (or your spouse or common-law partner)

To calculate this amount, fill out the line 7 section of Form TD1ON-WS.

8. Amounts transferred from your spouse or common-law partner – If your spouse or common-law partner will not use all of their age amount, pension income amount, or disability amount on their income tax and benefit return, enter the unused amount.

9. Amounts transferred from a dependant – If your dependant will not use all of their disability amount on their income tax and benefit return, enter the unused amount.

10. TOTAL CLAIM AMOUNT – Add lines 1 to 9.
Your employer or payer will use this amount to determine the amount of your provincial tax deductions.

Canada

Filling out Form TD1ON

Fill out this form only if you are an employee working in Ontario or a pensioner residing in Ontario and **any** of the following apply:

- you have a new employer or payer, and you will receive salary, wages, commissions, pensions, employment insurance benefits, or any other remuneration
- you want to change the amounts you previously claimed (for example, the number of your eligible dependants has changed)
- you want to increase the amount of tax deducted at source

Sign and date it, and give it to your employer or payer.

If you do not fill out Form TD1ON, your employer or payer will deduct taxes after allowing the basic personal amount **only**.

More than one employer or payer at the same time

☐ If you have more than one employer or payer at the same time and you have already claimed personal tax credit amounts on another Form TD1ON for 2024, you **cannot** claim them again. If your total income from all sources will be more than the personal tax credits you claimed on another Form TD1ON, check this box, enter "0" on line 10 and do not fill in lines 2 to 9.

Total income is less than the total claim amount

☐ Tick this box if your total income for the year from **all** employers and payers will be **less** than your total claim amount on line 10. Your employer or payer will not deduct tax from your earnings.

Additional tax to be deducted

If you want to have more tax deducted at source, fill out section "Additional tax to be deducted" on the federal Form TD.

Reduction in tax deductions

You may ask to have less tax deducted at source if you are eligible for deductions or non-refundable tax credits that are not listed on this form (for example, periodic contributions to a registered retirement savings plan (RRSP), child care or employment expenses, charitable donations, and tuition and education amounts carried forward from the previous year). To make this request, fill out Form T1213, Request to Reduce Tax Deductions at Source, to get a letter of authority from your tax services office. Give the letter of authority to your employer or payer. You do not need a letter of authority if your employer deducts RRSP contributions from your salary.

Forms and publications

To get our forms and publications, go to **canada.ca/cra-forms-publications** or call **1-800-959-5525**.

Personal information (including the SIN) is collected and used to administer or enforce the Income Tax Act and related programs and activities including administering tax, benefits, audit, compliance, and collection. The information collected may be disclosed to other federal, provincial, territorial, aboriginal or foreign government institutions to the extent authorized by law. Failure to provide this information may result in paying interest or penalties, or in other actions. Under the Privacy Act, individuals have a right of protection, access to and correction of their personal information, or to file a complaint with the Privacy Commissioner of Canada regarding the handling of their personal information. Refer to Personal Information Bank CRA PPU 120 on Information about Programs and Information Holdings at **canada.ca/cra-information-about-programs**.

Certification

I certify that the information given on this form is correct and complete.

Signature _____ Date _____

It is a serious offence to make a false return.

CONFIDENTIALITY AGREEMENT

Name: _____
(Please Print)

Affiliation with SHS: _____
(Example: employee, physician, researcher, student, vendor, volunteer)

1. During my association with Sinai Health System (SHS), I will have access to: (a) SHS corporate confidential or proprietary information relating to the organization's functions, employees and persons affiliated with SHS; and/or (b) personal health information relating to SHS patients, as such term is defined under the *Personal Health Information Protection Act*, 2004 (PHI).
2. At all times, I shall respect the privacy and dignity of patients, employees and all persons affiliated with SHS and I shall only collect, use and disclose personal information (including personal health information) as required by the duties of my position and in accordance with the laws of Ontario and Canada.
3. I shall not inappropriately access, use, copy, modify, remove, or disclose SHS corporate confidential or PHI.
4. This Agreement does not apply to information I previously and independently developed alone or with others prior to my association with SHS that I can substantiate by written records; nor to information in the public domain.
5. I shall maintain the secrecy of all User ID(s) and Password(s) that enable me to access SHS and/or Lunenfeld Tanenbaum Research Institute networks and applications and acknowledge that I am responsible for all access and/or actions carried out under them.
6. I acknowledge that SHS issues policies and procedures that relate to the protection of SHS confidential information and patient information and that compliance with these policies is a requirement of my association with SHS. These policies include, but are *not* limited to:

   - Privacy Policy;
   - Acceptable Use of Information and Information Technology;
   - Privacy Incident Protocol;
   - Other department specific policies and procedures

   I understand that it is my responsibility to familiarize myself with these policies and keep informed of any changes. If I have questions about privacy related policies, including their applicability to me or impact on the performance of my duties, I may contact my supervisor or the Privacy Office.
7. I shall immediately report all privacy breaches involving SHS confidential information and/or patient information to my immediate supervisor and to the SHS Privacy Office.
8. I understand that SHS will conduct periodic audits to ensure compliance with this Agreement and its privacy policies.
9. I also understand that should any of these conditions be breached, I may be subject to corrective action, up to and including termination of employment, loss of privileges, termination of contract, or similar action based on my association with SHS. I understand that a privacy breach is an offence under PHIPA and I may be subject to prosecution by provincial authorities if I am found guilty of this offence.
10. I understand and agree to abide by all of the conditions outlined above. Regardless of changes that may occur to my title, duties, status and/or other terms of my employment or association with SHS, I understand that the terms of this Agreement will continue to apply (including when I no longer have an association with SHS, no matter what the reasons).

Date: _____ Signature: _____ Department: _____

Last Revised: April 2019

Sinai Health | Mount Sinai Hospital
Joseph & Wolf Lebovic Health Complex

Effective Date: October 1995
Reviewed: April 1998
Reviewed: February 2008
Revised: December 2008

GENERAL MANUAL – POLICY/PROCEDURE

Issued By : Administration

Approved by: Medical Advisory Council(October 1994)/Board of Directors(June 1995), Board of Directors (Feb 2008)

Title : CONFLICT OF INTEREST POLICY & PROCEDURE

Policy Number: I-g-5-7

Key Words: Conflict of interest

Stakeholders:

Mount Sinai Hospital Board of Directors, Members of Board Committees, Employees, Medical Staff, Researchers, Students, Vendors and Volunteers

Policy Statement:

In order to maintain the highest standard of public trust and integrity, it is expected that all individuals associated with Mount Sinai Hospital will carry out their duties honestly, responsibly and in full accordance with the highest ethical and legal standards. It is recognized that potential and actual conflicts of interest may arise as individuals perform their duties and carry out related activities. As a first step in identifying and resolving conflicts of interest, all employees, appointees and medical staff shall immediately disclose any perceived potential or actual conflict of interest. In addition, all vendors providing goods and services to Mount Sinai Hospital shall also be required to disclose any perceived or actual conflict of interest.

An individual has a potential conflict of interest when that individual or member of his or her immediate family has the ability to influence directly or indirectly a decision or action of the Hospital that leads or could lead to a personal, financial or professional benefit for the individual or his or her family or when an individual's interest or actions are adverse to the interests of the Hospital.

The following are examples only and are not intended to be exhaustive. A situation or action does not need to occur as described to constitute a conflict of interest. Further, a potential as well as an actual conflict must be reported and it is important to consider the potential for conflict in each situation.

i. using privileged or confidential information for personal gain

ii. accepting or offering personal rewards in order to influence business transactions affecting the Hospital

iii. requesting or accepting money, gifts, gratuities, loans or service for personal or family benefit without full payment for value received, from an enterprise which does business with the Hospital

iv. conducting business on behalf of the Hospital with an enterprise which the employee or member of his or her immediate family has a personal or financial interest

v. using discoveries, inventions or other intellectual property rights of the Hospital or in which the Hospital has an interest for personal benefit without the prior, written permission of the Hospital

vi. using discoveries, inventions, information, ideas or data of Hospital researchers or other employees of the Hospital for personal benefit without the prior, written permission of such researcher or employee

vii. seeking or receiving funding or other considerations in regard to Hospital related activities without the prior, written permission of the Hospital

viii. participating in actions that would deprive the Hospital of the time and attention of staff required to perform their duties properly

ix. use of Hospital equipment, services or materials, personnel or trainees for personal gain or benefit

Effective Date: October 1995
Reviewed: April 1998
Reviewed: February 2008
Revised: December 2008

GENERAL MANUAL – POLICY/PROCEDURE

x. use of Hospital name or logo, for personal gain or benefit

xi. using one's position, influence or authority to promote the purchase, lease or use of goods or services used by the Hospital where the employee or member of his or her immediate family stands to gain financially from such promotion

An individual's failure to properly disclose an actual or potential conflict of interest may be grounds for corrective action, up to and including termination of his/her employment or contract with Mount Sinai Hospital.

Procedure:

A. Whether a conflict of interest exists will depend upon the circumstances of each case. It is the responsibility of all individuals associated with Mount Sinai Hospital to declare situations of actual or potential conflict of interest.

B. Board of Directors and individuals participating in, or having influence over, any purchasing process (including vendors) will be required to sign a declaration at the time of appointment and on an annual basis (see Appendix 38).

C. Other individuals associated with Mount Sinai Hospital will be required to communicate in writing at the earliest opportunity any actual or potential conflict of interest (see Appendix 38).

D. Conflicts shall be reported in writing, with sufficient detail, as follows:

   a. President and Chief Executive Officer & Executive Vice-President and Chief Operating Officer to Chair of the Board of Directors, whose decision will be subject to review by the Nominating and Governance Committee.

   b. Board of Directors to the President and Chief Executive Officer (or designate), whose decision will be subject to review by the Nominating and Governance Committee.

   c. Senior Management to the President and Chief Executive Officer whose decision will be subject to review by the Chair of the Board of Directors.

   d. Employees and Students to Department Head, whose decision will be subject to review by the respective Vice-President.

   e. Medical Staff to Department Chief, whose decision will be subject to review by the Medical Advisory Council Executive and the Chief Executive Officer.

   f. Researchers to Director of Research Institute, whose decision will be subject to review by the Vice-President, Research.

   g. Volunteers to the Director of Volunteer Services, whose decision will be subject to review by the Vice-President.

   h. Vendors to the Vice-President responsible for overseeing procurement.

A written response will be provided by the "immediate supervisor" to individuals who have communicated any actual or potential conflict of interest.

List of Appendices:

(see Appendix 38).

Sinai Health | Mount Sinai Hospital
Joseph & Wolf Lebovic Health Complex

CONFLICT OF INTEREST – DECLARATION FORM

Please review the Mount Sinai Hospital Conflict of Interest Policy & Procedure* prior to completing this form. Please speak to your immediate supervisor if you have any additional questions. Use extra paper if your response requires more space than available below.

1. Conflict of Interest – Outside Activity	
A.	Do you participate in outside activities which could represent a conflict of interest? (e.g., Board of Director position, outside employment, volunteer activity) **Yes☐ No☐**
	If "Yes", please describe the activities including the names of the outside parties with whom you are involved, your role, and your time commitment to the outside activities
2. Conflict of Interest – Personal Benefit / Gain	
A.	Do you or your Associate** receive a benefit from any outside organization that sells goods or services to Mount Sinai Hospital? **Yes☐ No☐**
	If "Yes", please describe the details of the benefit which could represent a conflict of interest. (e.g., receipt of a gift or payment from a vendor).
B.	Do you or your Associate** receive payment from the Hospital in addition to your regular salary or stipend? (e.g., fee-for-service payment, remuneration for consulting services) **Yes☐ No☐**
	If "Yes", please describe the fee-for-service arrangement or other remuneration that you or your Associate receives, not including your normal salary or stipend.
C.	Do you or your Associate** benefit from your Mount Sinai signing or other authority which could represent a conflict of interest? **Yes☐ No☐**
	If "Yes", please describe the benefit received from the Hospital signing or other authority which could represent a conflict of interest.
3. Conflict of Interest - Inappropriate Use of Hospital Resources or Information	
A.	Do you use the services of employees, students or others that your supervise, for a purpose other than your employment / professional obligations to Mount Sinai Hospital? (e.g., use of staff to support an outside business)? **Yes☐ No☐**
	If "Yes", please describe the nature and involvement of those employees, students, or others in that outside activity.
B.	Do you make significant use of Mount Sinai Hospital assets or resources to support activities outside of your employment / professional obligations to Mount Sinai Hospital? (e.g., use of office space, supplies, communication devices, or confidential information) **Yes☐ No☐**
	If "Yes", please describe the nature of each of the uses.
4. Other Conflicts	
A.	Are you aware of any other conflicts of interest or conflicts of commitment (perceived, potential or actual), involving you or your Associate**, that will affect your role with Mount Sinai Hospital? **Yes☐ No☐**
	If "Yes", please describe the nature of the perceived, potential, or actual conflict of interest and/or commitment.

* Mount Sinai Hospital Conflict of Interest Policy & Procedure, http://info2/policies/generalmanual/organization/ig57

** **Associate**: An immediate family member (Includes a parent, grandparent, sibling, spouse (including a life partner), child, grandchild, son-in-law, daughter-in-law, brother-in-law, sister-in-law and the parent, grandparent, sibling, child, grandchild, son in-law, daughter-in-law, brother-in-law, sister-in-law of the individual's spouse), close friend, or legal entity of which the individual is a director, officer, or owes a fiduciary duty

Sinai Health | Mount Sinai Hospital
Joseph & Wolf Lebovic Health Complex

CONFLICT OF INTEREST – DECLARATION FORM

Please print:

Name:	
Department:	
Email:	Phone:
Name of Supervisor (e.g., Manager, Chief):	
Supervisor's Title:	

Reporting Individual's Declaration

I declare that the information contained in this Declaration Report is true and correct to the best of my knowledge, information, and belief.

I will promptly submit a revised report if at any time my circumstances warrant a different response to any of the questions in this Declaration Report.

I have read the Mount Sinai Hospital's *Conflict of Interest Policy & Procedure* * and understand this Declaration is given in accordance with that *Policy.* I understand that if I have indicated that I may become involved in activities which could represent a conflict of interest or a conflict of commitment, I shall not engage in these activities until such time as the conflict considerations are assessed and resolved. If I have indicated that I am presently involved in activities which could represent a conflict of interest or a conflict of commitment, I understand that I may continue the activity until such time as the conflict considerations are assessed and resolved, unless I am ordered by my department head (in consultation with the appropriate Vice-President) to cease the activity. I understand that the order to cease the activity shall stand until such time as the conflict considerations are assessed and resolved.

The personal information collected in this form is collected in accordance with the *Freedom of Information and Protection of Privacy Act*, and will be maintained by the Human Resources Department or Medical Affairs Department for the purposes of managing conflicts of interest. If you have any questions about the collection, use and disclosure of personal information provided on this form, please contact the Hospital Freedom of Information Coordinator and Privacy Officer at privacy@mtsinai.on.ca.

Where public disclosure of information is required relating to an assessed conflict, you will be notified by Mount Sinai Hospital at that time.

_____ _____

Signature **Date**

Sinai Health | Mount Sinai Hospital
Joseph & Wolf Lebovic Health Complex

EMPLOYEE PROFILE DATA

Name: _____

Department: _____

Please complete all relevant sections and return to Human Resources, room 301 (main floor).

LICENSES:
(e.g. Ontario College of Nurses, Ontario College of Pharmacists, Basic Cardiac Life Support)
** Please be sure to provide the license number rather than the certificate number*

College	License Number*	Expiry Date

EDUCATION (*Completed Degrees):*

Degree (Bachelor, Masters, PhD)	Discipline	Institution	Yr Achieved

OTHER EDUCATION:

Course	Institution	Yr Completed

DESIGNATIONS/CERTIFICATION:
(e.g. Certified Oncology Nurse "CON", Chartered Accountant "CA")

Designation/Certification	Prov/Country	Yr Achieved

LANGUAGES:
(We are collecting this information to identify resources that may be able to assist, as necessary, in patient communications. Completion of this section is entirely optional.)

Language	Oral	Written