

Subrecipient/Collaborator FCOI form

Subrecipient/Collaborator: _____

Lead Principal Investigator/Collaborator: _____ Phone Number: _____

E-mail: _____ Sponsor (check one): NSF PHS Other _____

Grant# (if applicable): _____ BCM Reference # _____

1. Check here if you are the Authorized Representative for your Institution and are acknowledging that subrecipient/collaborator has a Financial Conflict of Interest (FCOI) policy that conforms to [2 CFR Part 200, Subpart B](#) and (if applicable) will monitor and report to Baylor College of Medicine each person defined as [Investigator](#) whether paid or unpaid for a FCOI prior to the expenditure of any funds or participation on the research project.
2. Check here if subrecipient/collaborator does not have a FCOI policy that conforms to 2 CFR Part 200, Subpart B; or if collaborator is working as a consultant not affiliated with an Institution or business.
 - 2a. No, I do not have [SFI\(s\)](#). No, I do not have [sponsored travel](#) to report that has occurred in the previous 12 months of this disclosure. As the lead Principal Investigator/collaborator, I am the Authorized Representative to sign this form. I have reviewed the definition of SFI and neither I nor my spouse or dependent children have an SFI that meets or exceeds the regulatory definition of an SFI related to my institutional responsibilities. As the Authorized Representative to sign this form, I further agree to conform to BCM's FCOI training requirement.
 - 2b. Yes, I have SFI(s) or have traveled in the previous 12 months with expenses reimbursed or sponsored and have appended a [travel document](#) to this form. As the Lead Principal Investigator/Collaborator, I am the Authorized Representative to sign this form. I have reviewed the definition of SFI and I, my spouse or dependent children have a SFI that meets or exceeds the regulatory definition of an SFI related to my institutional responsibilities. For SFIs that are not sponsored travel, please provide the name of the entity involved and specify the type of interest in the drop down box:

Should BCM get funding, I will provide more detail about my interests to the BCM Research Conflict of Interest Office. As the Authorized Representative to sign this form, I further agree to conform to BCM's FCOI training requirement.

This FCOI form is being submitted for an: **(please select one of the drop-down options):**

Notices regarding FCOI should be made to: Research Conflict of Interest Office, Baylor College of Medicine, One Baylor Plaza, MS: BCM310, Houston, TX 77030; research.coi@bcm.edu, 713-798-8217.

Certification: As the Authorized Representative, I certify that the statements herein are true, complete, and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. Furthermore, I certify that subrecipient/collaborator will comply to applicable FCOI regulations, including, but not limited to those set forth in 2 CFR Part 200, Subpart B. Furthermore, by signing this form, I agree that if BCM receives funding, BCM has the right to obtain additional information from an Investigator or subrecipient/collaborator for any disclosed information on this form. To review definitions and BCM policy please reference our [Financial Interests in Research Manual](#).

Authorized Representative signature: _____

Date _____

Print Name: _____