New Employee Documentation Checklist

Welcome to Sinai Health! Please follow the checklist below to complete the documentation required for employment. Please bring your completed documents on your first day for collection. Electronic signatures are accepted.

Document	Description and Instructions	Completed
Proof of Age and Eligibility to Work in Canada	Copies (scan or photo) of the following documents are required to be submitted with your documentation package: ✓ **Photo Identification** with proof of age (e.g., health card, driver's license, passport) ✓ **Social Insurance Number** (SIN) Card or other government documentation with SIN number. (Note: SINs that begin with a "9" must be accompanied with a valid work permit.)	☐
New Employee Documentation Package	Complete forms within the New Employee Documentation Package. ✓ **New Employee Information Form** ✓ **Direct Deposit Form** ✓ **Healthcare of Ontario Pension Plan Enrolment Form** ✓ **Federal Tax Form – TD1** ✓ **Provincial Tax Form – TD1ON** (Note: See Tips for Completing Tax Forms on page 5 of New Employee Documentation Package for more information.) ✓ **Conflict of Interest (COI) Declaration Form**	☐
Additional Documentation	Depending on your position, the following documents, as indicated in your offer letter, may also be required: ✓ Copy of any required educational qualifications for the position: degree(s), diploma(s), certificate(s) or transcripts ✓ Current registration with applicable college as required by your classification ✓ Copies of any required certifications as outlined in your offer letter ✓ Copy of current Basic Cardiac Life Support (BCLS) (where applicable) ✓ Letters for credit for past experience (where applicable)	☐

Notice of Collection

The personal information provided on the applicable forms allows us to process your payroll and benefits in relation to your employment contract. We collect this information under the authority of the Public Hospitals Act, Employment Standards Act and the Income Tax Act.

Should you have any questions, please contact the Human Resources office at:

- For Mount Sinai Hospital: 416-586-4800 ext. 5040
- For Hennick Bridgepoint Hospital: 416-461-8252 ext. 2007

CLEAR

New Employee Information Form

Employee Information

Sinai Health recognizes its obligation to respect privacy and is committed to maintaining the confidentiality and accuracy of employee information. As per Sinai Health's Confidentiality of Employee Information Policy, complete diligence is exercised in maintaining records that contain confidential information.

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

Preferred First Name: _____ **Date of Birth** (mm/dd/yyyy): _____

Social Insurance Number (please attach proof of SIN)**:** _____

Note: If your SIN begins with a "9"– please provide HR with a copy of your work permit or proof of maintained status.

Work Permit/Visa Expiry: (mm/dd/yyyy)**:** _____

Legal Sex*: ☐ Male ☐ Female ☐ X

*Legal Sex is mandatory to collect for insurance purposes

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Primary Phone #: _____ **Secondary Phone #:** _____

Personal Email Address: _____

All communications to active employees through Sinai Health will be sent to their corporate email address. Your personal email address will be used for communications while you are on an approved leave of absence or after departing from the organization.

Emergency Contacts

Employees must name **at least one** emergency contact. This information is mandatory and will be kept strictly confidential. Your emergency contact(s) listed below will be contacted only in the event of an emergency.

Contact Name 1: _____ **Relationship:** _____

Primary Phone #: _____ **Secondary Phone #:** _____

Contact Name 2: _____ **Relationship:** _____

Primary Phone #: _____ **Secondary Phone #:** _____

Direct Deposit Form

Direct Deposit Authorization

Name (please print): _____

I authorize Sinai Health to deposit my wages every two weeks into the following bank account:

Transit Number: _____

Institution Number: _____

Account Number: _____

Signature: _____ **Date:** _____

Please attach a void cheque or authorized direct deposit form from your financial institution.

Optional - Secondary Account Information

You may choose to assign a flat dollar amount to be deposited to a second account each pay. If you have a second account, please complete the information below and attach a second void cheque or direct deposit form.

Please deposit $ _____ to the account ending in _____

Important notes regarding your pay:

- Using an Institution other than a major Canadian bank may delay your payroll deposits.
- If changing your Bank Account, please do not close your current account until after your first pay has been deposited into your new account.
- The payroll calendars for Hennick Bridgepoint Hospital and Mount Sinai Hospital are available on each site's HR intranet/portal page, which you will get access to during your first week.

For HR Use Only

Entered by: _____ Date: _____

Verified by: _____ Date: _____

Healthcare of Ontario Pension Plan Enrolment Form

The Healthcare of Ontario Pension Plan (HOOPP) is a private trust fund operating on a not-for-profit basis, set up for the sole purpose of administering and providing defined benefit (DB) pensions for more than 435,000 health-care workers in Ontario.

The amount you contribute is based on how much you earn and the Plan's contribution rates. The current rates are 6.9% up to the year's maximum pensionable earnings (YMPE) and 9.2% above the YMPE. These rates have been in place since 2004.

To learn more about the features of the pension plan and the benefits of joining, please visit HOOPP's website or review the HOOPP Handbook.

Regular Full-time Employees

Participation in HOOPP is mandatory and a condition of employment for regular full-time hourly employees. Regular full-time hourly employees must enrol in HOOPP immediately upon date of hire or transfer to full-time status. No action is required; you will be automatically enrolled.

Part-time, Casual and Contract Employees

Participation in HOOPP is optional for part-time, casual and contract hourly employees. If you do not choose to enrol immediately, you may choose to join HOOPP on any subsequent date. If you choose to join HOOPP, you must continue to make contributions on your pensionable earnings as long as you are employed at Sinai Health. You may only choose to stop making contributions at an employer where you work part-time if you later become a full-time employee at another HOOPP employer.

Enrolment/Waiver Form for Part-time, Casual and Contract Employees Only

I have been advised that I am eligible to enrol in the Healthcare of Ontario Pension Plan as a part-time, casual or contract employee of Sinai Health. I confirm that:

- ◯ I would like to enrol in HOOPP as of my start date.
- ◯ I have read the information in my new employee package and I am declining 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 at any time on a go forward basis (not retroactive) by providing my employer with written notification of my intention to enrol; 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 Name: _____

Employee Signature: _____

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

Tips for Completing Tax Forms

New employees must complete the TD1 and TD1ON forms when they are hired, and are not required to complete them again unless there is a change which may reasonably be expected to result in a change to their personal tax credits. When a change occurs, new forms must be completed and submitted to the HR Department.

Everyone is entitled to the Basic Personal Amount listed in Line 1 of each form, but there may be other exemptions to which you are entitled. Read each line carefully and complete those that apply to you. Once all applicable sections have been completed, add up all lines to populate your Total Claim Amount.

If you require tax advice, please speak to a Professional Accountant or Tax Specialist.

Total income is less than the total claim amount

This indicates that total income for the year will be less than total claim amount on the TD1 form. Tax will not be deducted from earnings; if it turns out that you earn more than your personal tax credits, when you file your tax return you will have some tax owing.

More than one employer or payer at the same time

This indicates that an employee has more than one employer, and is already claiming personal tax credit amounts on another TD1 form with another employer. Personal tax credit claims can only be claimed once, so the box "More than one employer or payer at the same time" on the back of the TD1 form for the second employer should be ticked, and "0" should be entered as "Total Claim Amount" on page 1 of the TD1. This will result in taxes being deducted from all earnings, without taking any personal tax credit amounts into account (as they have already been claimed elsewhere).

Note: If someone has multiple employers but the total income from all employers and payers will be less than the total claim amount on the TD1, do not tick the "More than one employer" box. Instead, tick the "Total income less than total claim amount" box, so that taxes will not be deducted from earnings. Both boxes should not be selected at the same time.

Additional taxes

On the back of the TD1 form, there is a section called "Additional tax to be deducted." This is where you can specify a flat amount of additional taxes to be deducted from your pay deposit each biweekly pay period. If you have income from other sources, this can help reduce the amount owing when you file your tax return.

When to update tax forms

Employees should submit new tax forms when a change in circumstances may result in a change to their personal tax credits. Examples include a change in marital status, a dependent becoming disabled, getting a second job, or earning significantly more than before (based on an increase in salary or hours worked).

Tips

If you would like to learn more about personal income tax and filling TD1 forms, visit the Canada Revenue Agency:
https://www.canada.ca/en/revenue-agency/services/tax/individuals/educational-programs.html

Protected B when completed

TD1

2024 Personal Tax Credits Return

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	Date of birth (MM/DD/YYYY)	
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.

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	Date of birth (MM/DD/YYYY)	
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.

GENERAL MANUAL – POLICY / PROCEDURE

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

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:

Sinai Health 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 Sinai Health 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 Sinai Health 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 Sinai Health 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 Sinai Health.

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 Sinai Health

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 Sinai Health

iv. conducting business on behalf of Sinai Health 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 Sinai Health or in which the Sinai Health has an interest for personal benefit without the prior, written permission of Sinai Health

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

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

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

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

x. use of Sinai Health 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 Sinai Health where the employee or member of his or her immediate family stands to gain financially from such promotion

xii. 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 Sinai Health.

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 Sinai Health 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 Sinai Health 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).

CONFLICT OF INTEREST – DECLARATION FORM

Please review Sinai Health's Conflict of Interest Policy & Procedure (see above) 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 Sinai Health? **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 Sinai Health 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 Sinai Health signing or other authority which could represent a conflict of interest? **Yes** ◯ **No** ◯
	If "Yes", please describe the benefit received from Sinai Health 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 Sinai Health? (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 Sinai Health assets or resources to support activities outside of your employment / professional obligations to Sinai Health? (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 Sinai Health? **Yes** ◯ **No** ◯
	If "Yes", please describe the nature of the perceived, potential, or actual conflict of interest and/or commitment.

**** 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

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 Sinai Health'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 Privacy Office at privacyoffice@sinaihealth.ca.

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

_____ _____

Signature **Date**