

OUTSIDE COMPENSATION DISCLOSURE STATEMENT

Medical Practice Income Plan **TTUHSC School of Medicine**

I, _____ (*Name*), a Faculty/Provider of Professional Services at the Texas Tech University Health Sciences Center (TTUHSC) School of Medicine, hereby acknowledge my obligation to the School of Medicine with regard to outside compensation from professional services.

In accordance with the MPIP Bylaws, TTUHSC OP 70.18, and the SOM OP 20.30, Outside Compensation to Clinical Faculty, I acknowledge the following as a true and complete disclosure representing any and all outside compensation I have received as a result of providing professional services:

Outside Compensation received between September 1, 20__ and August 31, 20__

Source of Compensation	Professional Services Provided	Amount Received	Date(s) Received

FACULTY/PROVIDER

Date

(*Printed Name*)

DEPARTMENT