

Health Technology Clinical Committee

Conflict of Interest Disclosure

Instructions

This conflict of interest (COI) form must be completed by an applicant for appointment to the state of Washington Health Technology Clinical Committee (HTCC) or clinical expert serving in a temporary capacity on the HTCC, as well as appointment to any of its subcommittees or work groups.

Those wishing to provide public comment at HTCC meetings are also requested to complete this COI form, but are not required to do so.

Instructions specific to HTCC applicants

As stewards of public funds, the practicing clinicians who serve (or apply to serve) on the Committee strive to uphold the highest standards of transparency and impartiality. Identifying financial, professional, and other interests contributes to the effective management of perceived, potential, and/or real conflicts of interest/bias that could affect Committee determinations (WAC 182-55). Management of potential conflicts of interest on specific topics are addressed in committee bylaws.

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Applicant information

First name:

Middle initial:

Last name:

Phone number:

Email:

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Financial interests

Disclose your financial interests and relationships occurring over the last twenty-four months.

List amounts totaling \$1,000 or more from a single source.

Indicate the category of financial interest/relationship by referring to the disclosure categories below. Select the letter corresponding to your financial interest(s). You may indicate multiple categories.

Indicate the source and date of the financial interest. For each chosen category, include date and if your activities are ongoing.

Indicate the recipient. Family: spouse, domestic partner, child, stepchild, parent, sibling (his/her spouse or domestic partner) currently living in your home.

Financial interest categories

Use these categories to indicate the nature of the financial interest:

- | | | |
|--|--|---|
| A. Payment from parties with a financial or political interest in the outcome of work as part of your appointment or activity. | C. Ownership or owning stock (stock, options, warrants) or holding debt or other significant proprietary interests or investments in any third party that could be affected. | D. Receiving a proprietary research grant or receiving patents, royalties, or licensing fees. |
| B. Employment including work as an independent contractor, consultant, whether written or unwritten. | | E. Participating on a company's proprietary governing boards. |
| | | F. Participating in a speakers bureau. |
| | | G. Receiving honoraria. |

Please list your financial interests on the next page. Attach additional sheets if necessary.

Financial interest disclosures

Category (A-G)	Source of income and date	Amount	Recipient
			Self Family
			Self Family
			Self Family
			Self Family
			Self Family
			Self Family
			Self Family

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Other interests

Please respond to the following questions. Disclose all interests that may apply to health technology assessment (HTA) topics covered in upcoming meetings.

Have you authored, coauthored, or publicly provided an opinion, editorial, or publication related to any meeting topic? Topic(s):

Are you involved in formulating policy positions or clinical guidelines related to any meeting topic? Topic(s):

Could a coverage determination based on a Committee topic conflict with policies you have promoted or are obliged to follow? Topic(s):

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Signature

I have read the Conflict of Interest Disclosure form. I understand the purpose of the form and agree to the application of the information to determine conflicts of interest. The information provided is true and complete as of the date the form was signed. If circumstances change, I am responsible for notifying HTA program staff in order to amend this disclosure. I will complete this form annually by July 1st of each year of committee membership (*applies to HTCC committee only*).

To sign this request, do not use the "Fill & Sign" function; instead, simply click in the signature field to add your signature.

Signature

Date

Download this form and send the completed version to htap@hca.wa.gov.

Or mail to:
Health Technology Assessment Program
Washington State Health Care Authority
P.O. Box 42712
Olympia, WA 98504-2712