

# Health Technology Clinical Committee

## Application for Membership



### 1 Contact information

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First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Last name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Best method, time to reach you: \_\_\_\_\_

Email: \_\_\_\_\_ Today's date: \_\_\_\_\_

### 2 Personal information (optional)

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Gender:  
Male      Female      X/non-binary<sup>1</sup>

Pronouns (select all that apply)  
She/her      He/him      They/them      Other (subj./obj.): \_\_\_\_\_

Race or Ethnicity  
American Indian or Alaska Native      Asian or Pacific Islander American  
Black/ African American      Latino, Hispanic, Spanish  
White/ Caucasian      Other: \_\_\_\_\_

### 3 Professional training

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Education (list degrees): \_\_\_\_\_

Health care practitioner licenses: \_\_\_\_\_

Professional affiliations: \_\_\_\_\_

Board certifications, formal training, or other designations: \_\_\_\_\_

Current position (title and employer): \_\_\_\_\_

Current practice type and years in practice: \_\_\_\_\_ Total years as an active practitioner: \_\_\_\_\_

Location of practice (city): \_\_\_\_\_

<sup>1</sup> Non-binary (X) is an umbrella term used to describe those who do not identify as exclusively male or female. This includes but is not limited to people who identify as genderqueer, gender fluid, agender, or bigender.



## 5

## Ability to serve

Are you able to participate in all-day meetings, an estimated six times per year?	Yes	No
Are you willing to commit to the responsibilities of a committee member, including: <ul style="list-style-type: none"><li>• Attending meetings prepared for the topics of the day;</li><li>• Actively participating in discussions;</li><li>• Making decisions based on the evidence presented and the public interest<sup>1</sup>?</li></ul>	Yes	No
Could you, or any relative, benefit financially from the decisions made by the HTCC?	Yes	No

## 6

## References

Provide three professional references:

1. First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Title: \_\_\_\_\_

Contact email: \_\_\_\_\_ Phone number: \_\_\_\_\_
2. First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Title: \_\_\_\_\_

Contact email: \_\_\_\_\_ Phone number: \_\_\_\_\_
3. First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Title: \_\_\_\_\_

Contact email: \_\_\_\_\_ Phone number: \_\_\_\_\_

### For your application to be reviewed, please include:

Completed application

curriculum vitae

[conflict of interest disclosure](#) 

Download this form and send the completed version to [shtap@hca.wa.gov](mailto:shtap@hca.wa.gov)

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

<sup>1</sup> Detailed in Washington Administrative Code (WAC) and committee bylaws