Health Technology Clinical Committee Application for Membership

Washington State Health Care Authority

1 Contact information

First name:

Middle initial:

Last name:

Address:

Phone number:

Best method, time to reach you:

Email:

Today's date

2 Personal information (optional)

Gender:

☐ Male ☐ Female ☐ X/non-binary[1]

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

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):

1 *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.*

4 Experience

Provide a brief explanation (up to 150 words each) addressing the following:

1) Why you would like to serve on the clinical committee;

2) The value of informing health policy decisions with scientific evidence, including any examples incorporating new evidence into your practice;

3) How your training and experience will inform your role on the committee

4) Treating populations that may be underrepresented in clinical trials: women, children, elderly, or people with diverse ethnic and racial backgrounds, including recipients of Medicaid or other social safety net programs?

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:

- Attending meetings prepared for the topics of the day;
- Actively participating in discussions;
- Making decisions based on the evidence presented and the public interest1? ☐ 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**

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

1 *Detailed in Washington Administrative Code (WAC) and committee bylaws*