**Health Technology Clinical Committee
Application for Membership**

**Contact information**

Name:

Address:

Phone number:       Best method and time to reach you:

Email:

Are you: Applying for membership [ ]  Yes ***or***
Nominating another person for membership? [ ]

Name of nominee:

**Training and experience**

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/state):

Describe your experience treating women, children, elderly persons, or people with diverse ethnic and racial backgrounds.

**Ability to serve**

1. Are you able to participate in all-day meetings, an estimated five times per year? [ ]  Yes [ ]  No
2. 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
1. Could you, or any relative, benefit financially from the decisions made by the HTCC? [ ]  Yes [ ]  No
2. Provide a brief explanation (up to 500 words) of why you would like to serve on the clinical committee and the contributions you would like to make.

1Detailed in state regulations and committee bylaws.

**References**

Provide three professional references including: name, title, relationship, contact email and phone number.

1.

2.

3**.**

**Personal Information***(Optional)*

**Gender:** [ ]  Male [ ]  Female

**Race or Ethnicity**

[ ]  American Indian or Alaska Native [ ]  Asian or Pacific Islander American

[ ]  Black/ African American [ ]  Latino, Hispanic, Spanish

[ ]  White/ Caucasian [ ]  Other:

**Military Service**

If you have served in active duty in the U.S. Armed Forces. List branch, dates and type of discharge:

**Disability**

Do you have a permanent physical, sensory, or mental condition that limits your major life functions? (Examples include working, caring for yourself, walking, doing things with your hands, seeing, hearing, speaking or learning: [ ]  Yes [ ]  No

If “yes,” please explain:

**Return completed, saved application curriculum vitae and conflict of interest disclosure form (linked on HTA website to:**

**shtap@hca.wa.gov****; or**

**Health Technology Assessment Program**

**Washington State Health Care Authority**

**P.O. Box 42712**

**Olympia, WA 98504-2712**