



Florida AIDS Drug Assistance Program (ADAP) WORKGROUP ON ADAP MEMBERSHIP APPLICATION



Date: _____

Prefix Preference (Select One): Dr. Mr. Mrs. Ms. Miss None

Last Name: _____ **First Name:** _____ **Middle Initial:** ____ **Suffix (if any):** ____

Mailing Address: _____

City: _____

State: _____

County: _____

Zip Code: _____

Email: _____

Organizational Affiliation: _____

Address: _____

City: _____ **Zip Code:** _____

Employer (if applicable): _____

Do you have a phone so that we may contact you for participation on particular ADAP Advisory Workgroup calls?

Work Phone: _____ **Fax Number:** _____

Home or Cell Phone: _____ **Other Contact Number:** _____

Title: _____

<p>Sexual Orientation (optional):</p> <p><input type="checkbox"/> Bisexual</p> <p><input type="checkbox"/> Heterosexual</p> <p><input type="checkbox"/> Homosexual</p> <p><input type="checkbox"/> Transgender</p>	<p>Race/Ethnicity (optional):</p> <p><input type="checkbox"/> American Indian/Alaskan Native</p> <p><input type="checkbox"/> Asian/Pacific Islander</p> <p><input type="checkbox"/> Black/African American</p> <p><input type="checkbox"/> Haitian (Any Race)</p> <p><input type="checkbox"/> Hispanic (Any Race)</p> <p><input type="checkbox"/> White/Caucasian</p> <p><input type="checkbox"/> Other (Specify) _____</p>
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Category of Representation: (Please select the category you wish to represent on the workgroup)

ADAP Consumer HIV/AIDS Physician

ADAP Consumer (Alternate) Person Living with HIV/AIDS (PLWHA)

ADAP County Contact RW Part A Representative

AETC Representative RW Part B Representative

AHCA/Medicaid Representative RW Part C Representative

HIV/AIDS ADAP Pharmacist HIV/AIDS Case Manager/Worker

HIV/AIDS Program Coordinator (HAPC) Comments: _____

HIV/AIDS Nurse





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Please answer the following questions as completely as possible.
(Use the back of the page and additional paper if necessary.)

What additional skills or expertise do you possess that you believe would be beneficial to the Workgroup?

Have you had any health planning experience, committee advisory experience, or been involved with a group that is similar to the HIV/AIDS Section Workgroup on ADAP? If so, please describe.

What experience do you have with the AIDS Drug Assistance Program (ADAP) that you feel would be beneficial to this group?

Why are you interested in becoming a member of the HIV/AIDS Section Workgroup on ADAP?

Do you have a web-cam already connected to or installed on your desktop/laptop?

Do you have a high-speed internet connection of at least four megabytes per second download speed and one megabyte per second upload speed?(To test connection speed: <http://www.speedtest.net>)

Do you own individual stock in a pharmaceutical company or companies (this excludes stock that may be owned as a component of a portfolio for which you have no control in determining its content)? If yes, please disclose the name(s) and number of shares.

In ADAP, our mission is to provide life saving medications, disease management training, and information to our clients in a cost effective manner. How do you feel you can help the program continue to accomplish this mission?

Is there any additional information you would like to share for consideration of your application?

If you serve as an ADAP consumer representative, you must be willing to publicly acknowledge your HIV status. If you are HIV-positive but serving on the group in another role, it is not required that you specify/acknowledge your HIV status. The HIV/AIDS Section Workgroup on ADAP is in agreement to disclose HIV status openly on the program website and for public engagements. Are you willing to share your HIV status with the public?

Yes No



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Additional Information Required

1) A Minimum of Two (2) References

(Additional references may be provided if desired. Please use the back of the page and additional paper if necessary.)

Reference 1: Name: _____ Phone Number: _____

Reference 2: Name: _____ Phone Number: _____

2) Two (2) Letters of Recommendation Documenting Your Community Involvement

The letters should be sent by the person providing the recommendation to the attention of Annie Farlin by mail or fax:

Mailing Address: Florida Department of Health
HIV/AIDS Section
4052 Bald Cypress Way, Bin A-09
Tallahassee, Florida 32399-1715

Fax Number: (850) 414-0038

Eligibility Criteria:

- The HIV/AIDS Section Workgroup on ADAP is open to interested parties in all areas of the HIV/AIDS community.
- The ADAP program provides direct drug assistance. Workgroup members will be asked to make objective decisions about the clinical and programmatic merit of specific drugs, along with other aspects of the program. For this reason, it is imperative that workgroup members have no conflicts of interest, such as employment with pharmaceutical companies or companies that provide pharmaceutical services.
- No member may receive inappropriate compensation while serving on the HIV/AIDS Section Workgroup on ADAP. The proposed interpretation of the restriction on compensation is as follows:
 - Pharmaceutical companies routinely sponsor conferences, receptions, and educational programs that include refreshments and/or meals which are available to all attendees. These events are not viewed as compensation to any individual and participation would not be problematic.
 - Pharmaceutical companies often provide unrestricted educational grants to AIDS Service Organizations and Community Based Organizations. These are generally not considered to be individual compensation and a workgroup member's affiliation with such an organization would not affect eligibility.
 - Scholarships for attendance at educational conferences or programs sponsored by pharmaceutical companies do not affect eligibility.
 - Consumers may also receive complimentary meals or refreshments from a pharmaceutical representative when attending meetings or conferences. This does not affect eligibility.
 - Direct payments made to an individual for conference presentations or for serving on a speaker's board for a pharmaceutical company is considered to be a conflict of interest.





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If you have any questions related to this matter or feel there are other financial relationships with the pharmaceutical industry not addressed above, please contact the Chair of the HIV/AIDS Section Workgroup on ADAP for clarification.

Statement of Eligibility:

I hereby certify, through signature on this application, that I have met the membership requirements. I agree not to accept or solicit any benefit that might reasonably tend to influence me in regard to my duties as a member of the workgroup. If I have a direct financial interest in a matter brought before the workgroup, I will disclose this and recuse myself from participation.

By signing this application, I certify that all information contained herein is true and accurate to the best of my knowledge and understanding. I also certify that I have read and understand the membership requirements and by-laws and, if accepted for membership, will fulfill all membership requirements as put forth by the HIV/AIDS Section, AIDS Drug Assistance Program (ADAP).

Signature:

Date:

