# Florida Department of Health HIV/AIDS Section
# HIV SECTION MEDICATION FORMULARY WORKGROUP (HSMFW) MEMBERSHIP APPLICATION

**HSMFW Application Date**: _____

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

**Last Name**: _____ **First Name**: _____ **Middle Initial**: ___

☐ APRN ☐ DO ☐ MD ☐ MPH ☐ PA ☐ PharmD ☐ RN ☐ Other: _____

**Title**: _____

**Employer** (if applicable): _____

**Organizational Affiliation** (if applicable: _____

**Address**: _____

**City**: _____ **State**: _____ **ZIP Code**: _____ **County**: _____

**Email**: _____

**Phone**

**Preferred Phone**: _____ ☐ Cell ☐ Work ☐ Home

**Secondary Phone**: _____ ☐ Cell ☐ Work ☐ Home

**Sexual Orientation (optional)**:

☐ Bisexual
☐ Heterosexual
☐ Gay
☐ Other _____

**Race/Ethnicity (optional)**:

☐ American Indian/Alaskan Native
☐ Asian/Pacific Islander
☐ Black/African American
☐ Haitian (Any Race)
☐ Hispanic (Any Race)
☐ White/Caucasian
☐ Other _____

**Gender (optional):**

☐ Please write in: _____

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**Category of Representation:** Please select the category or categories you wish to represent on the workgroup.

- ☐ ADAP Consumer
- ☐ Person with HIV
- ☐ RW Part A Representative
- ☐ RW Part B Representative
- ☐ RW Part C Representative
- ☐ RW Part D Representative
- ☐ HIV Clinician (MD, DO, APRN, PA)
- ☐ HIV RN/LPN
- ☐ Medical Case Manager
- ☐ Pharmacist
- ☐ AETC Representative (RW Part F)

**In addition to the application form, please list two references who can attest to your qualifications for HSMFW membership.**

**Name:** _____
**Job Title (if applicable):** _____
**Organization Name (if appliable):** _____
**Address:** _____
**Email:** _____
**Phone:** _____
**Relationship to applicant:**
☐ **Colleague** ☐ **Supervisor** ☐ **Direct Report** ☐ **Other:** _____

**Name:** _____
**Job Title (if applicable):** _____
**Organization Name (if appliable):** _____
**Address:** _____
**Email:** _____
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**Please answer the following questions as completely as possible.**
**(Include additional pages if necessary.)**

***Why are you interested in becoming a member of the HSMFW?***

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

***Have you had any health planning experience or committee advisory experience or been involved with a group that is like the HSMFW? If so, please describe.***

***Do you have any potential conflicts of interest (as outlined on the last page) to disclose? If so, please list please list the name(s) of the commercial entity/entities and describe financial relationship (e.g., grant/research support, consultant, speakers' bureau, stockholder, employment) below.***

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

***Will you be able to complete a two- or three-year appointment if selected?***

***If you elect to serve HSMFW as an ADAP consumer or person with HIV 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. Are you willing to share your HIV status with the public?**

☐ **Yes** ☐ **No**

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**Eligibility Criteria**:

- The HIV/AIDS Section HSMFW is open to interested parties in all areas of the HIV/AIDS community.

- New members will be appointed for a term of at least two or three years, as the needs of the workgroup dictate. Please refer to the by-laws for further information on new member appointments, terms, and duties.

- The AIDS Drug Assistance Program (ADAP) and other programs within the HIV/AIDS Section provide 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 disclose potential conflicts of interest, such as employment with pharmaceutical companies or companies that provide pharmaceutical services.

- No member may receive unallowable compensation while serving on the HSMFW. 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 that 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 a conflict of interest.

If you have any questions regarding eligibility or any other aspect of the application or HSMFW, please contact Dr. Andréa Sciberras, Medical Director, Division of Disease Control and Health Protection and Dr. Joanne Urban, HIV/AIDS Section Clinical Pharmacist at HIVMedicalTeam@flhealth.gov.

Send the completed application via email to HIVMedicalTeam@flhealth.gov.

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**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 regarding 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 in voting.

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 understood the membership requirements and by-laws and that, if accepted for membership, I will fulfill all membership requirements as put forth by the HIV Section Medication Formulary Workgroup.

Signature:

Date: