



## B. Official Organization Representative to WA CARES Partnership

This person serves in the official organization representative capacity, as needed. In addition, this person participates in Partnership activities as an interested member from the organization.

Designated *Official Representative*: \_\_\_\_\_  
*Printed name/credentials* *Title*

\_\_\_\_\_  
*Signature* *Date*

2. Mailing Address: \_\_\_\_\_ Physical Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Administrative Assistant** - Please indicate if there is an additional person through whom you would like us to correspond.

Assistant's Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Committee Selection** - Please select the committee(s) with which you would like to be involved.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Primary Prevention           | <input type="checkbox"/> Skin Cancer Task Force     | <input type="checkbox"/> Survivorship Task Force             |
| <input type="checkbox"/> Colorectal Cancer Task Force | <input type="checkbox"/> Prostate Cancer Task Force | <input type="checkbox"/> Breast & Cervical Cancer Task Force |
| <input type="checkbox"/> Membership/Communications    | <input type="checkbox"/> Public Policy              | <input type="checkbox"/> Surveillance & Evaluation           |

## C. Alternate Organization Representative to WA CARES Partnership

This person takes the place of the official organization representative when needed. In addition, this person participates in Partnership activities as an interested member from the organization.

Designated *Alternate Representative*: \_\_\_\_\_  
*Printed name/credentials* *Title*

\_\_\_\_\_  
*Signature* *Date*

Mailing Address: \_\_\_\_\_ Physical Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Administrative Assistant** - Please indicate if there is an additional person through whom you would like us to correspond.

Assistant's Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Committee Selection** - Please select the committee(s) with which you would like to be involved.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Primary Prevention           | <input type="checkbox"/> Skin Cancer Task Force     | <input type="checkbox"/> Survivorship Task Force             |
| <input type="checkbox"/> Colorectal Cancer Task Force | <input type="checkbox"/> Prostate Cancer Task Force | <input type="checkbox"/> Breast & Cervical Cancer Task Force |
| <input type="checkbox"/> Membership/Communications    | <input type="checkbox"/> Public Policy              | <input type="checkbox"/> Surveillance & Evaluation           |



## CONFLICT OF INTEREST POLICY

This conflict of interest policy pertains to organizational and independent members of the Washington CARES About Cancer Partnership (the Partnership) and members of any committee, task force, or work group of the Partnership. If such a member, or an organization which the member represents, has, or is about to assume, any direct or indirect financial interest in a transaction with the Partnership, such member or organization shall make full disclosure to the Steering Committee of such interest before any discussion or negotiation of such transaction and shall refrain from participating in discussions or voting on that particular transaction. This same member shall not attempt to exert any influence on the Partnership, whether in the Steering Committee, an operational or plan implementation committee, a task force, or a work group, or upon any participation in a Partnership decision-making process.

**At the date on which the member becomes associated with the Partnership, that member, or the organization which the member represents, shall sign a *Conflict of Interest Disclosure Statement* that will be kept on file with Partnership records.** The statement will be signed annually. The Comprehensive Cancer Control Program of the Washington State Department of Health shall be responsible for maintaining the records and keeping all signatures of member statements current.

## STATEMENT OF AGREEMENT TO ABIDE BY THE POLICY

I have read, understood, and agree to abide by the *Conflict of Interest Policy* for the Washington CARES About Cancer Partnership.

Full Name (printed) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Organization (if applicable) \_\_\_\_\_