



SOCIETY OF
CARDIOVASCULAR
COMPUTED TOMOGRAPHY

BE PART OF THE SCCT GRASSROOTS COALITION

Dear SCCT Member:

SCCT is working hard to communicate with legislators, policymakers and payers regarding the importance of preserving patient access to coronary computed tomographic angiography (coronary CT angiography). **We need you to become an active participant in this process.** The challenges we face in health care reform are significant. Patient access to imaging services will be threatened and providers are on the verge of extraordinary cuts in reimbursement.

YOUR voice counts most when dealing with your U.S. Representative, Senators, State legislators and local payers.

We ask that you please sign up to participate in the SCCT GRASSROOTS COALITION.

Name _____

Below is a brief questionnaire we request you complete.

LEGISLATIVE

1. Do you have a personal or professional relationship with a member of the U.S. House of Representatives, U.S. Senate, or an elected official in your state legislature?

YES ___

NO ___

Please mark the appropriate answer. If yes, please indicate the name and office of the official.

2. Have you participated in any of the following political activities?
 - a. Meeting with a legislator ___
 - b. Political fundraiser ___
 - c. Town hall event ___
 - d. Campaign activities ___
 - e. Federal or state lobby day ___
 - f. Ran for political office ___

Please mark the activities in which you have participated.

3. Would you be willing to participate in the following advocacy activities, with guidance from SCCT?
- a. Write, call or email your legislators regarding key issues for SCCT members ____
 - b. Meet with your legislators in their local district offices ____
 - c. Attend a local town hall meeting held by your legislators ____
 - d. Travel to Washington, DC to participate in a SCCT lobby day ____
 - e. Host a "Doctor for a Day" program at your facility ____

Please mark any of the activities you are willing to participate in.

PAYER

Are you willing to participate in advocacy efforts with local Medicare carriers?

YES ____

NO ____

Please mark your choice.

Are you willing to participate in advocacy efforts with local private payers?

YES ____

NO ____

Please mark your choice.

OFFICE CONTACT INFORMATION

Practice/Institution Name:

Address:

City/State/Zip:

Office phone:

Name of assistant and/or practice administrator _____

Please email this form as soon as possible to Carrie Kovar at ckovar@scct.org

THANK YOU FOR YOUR TIME!