



# NORTH CAROLINA COLLEGE OF EMERGENCY PHYSICIANS

JANUARY 2006

## PRESIDENT'S MESSAGE



Gregory Risk, MD FACEP  
NCCEP President

### The Ball is Rolling

As most of you are aware by now The National Report Card on the State of Emergency Medicine has been released.

There has been a great deal of media interest and some misunderstanding about the content and intent of the report. This report represents a starting point for us to engage in the discussion about the state of emergency medical services and systems in North Carolina.

The ACEP Report Card is based on four factors: Access to Emergency Care, Quality and Patient Safety, Public Health and Injury Prevention, and Medical Liability Environment. North Carolina received an overall grade of C-.

The state received a grade of C- for Access to Emergency Care, C for

Quality Patient Safety, B+ for Public Health, and an F for Medical Liability Environment. The F grade in Medical Liability relates to the lack of any cap on non-economic damages, lack of protections for EMTALA mandated care, and lack of expert witness rules, pretrial screening, joint liability reform and collateral source rules. Further information about each of these items, and details can be found in the report online at [www.acep.org](http://www.acep.org).

As a group, this report card is a beginning point. It is our opportunity to begin to educate legislators, patients, and other decision makers about the work that needs to be done to improve emergency systems. The emphasis during this year is on building relationships with those in a position to influence the debate, to build coalitions with groups who may have similar interests. More importantly, it is to build the infrastructure within our College to be able to engage and affect change. The committee structure within NC College of Emergency Physicians is being reinvigorated.

Our hope is to build an energized base, and to enlarge the number of emergency physicians who are engaged through activity, communication, or giving. We are in the process of activating and building Political Action Committees (PAC) with a regional orientation, and increasing the size and scope of the NCCEP PAC.

We have a resolution which was

introduced at the North Carolina Medical Society's Annual Meeting in November. This resolution would allow for changes in medical liability for EMTALA mandated care. It would include not only emergency physicians, but all on-call physicians. It recognizes the difficulties inherent in providing care to patients while on call, with no prior patient relationship, limited access to records, and often no reimbursement. Changing the standard to gross negligence and placing limits on non-economic damages might provide some relief to beleaguered call panels, who are choosing to opt out of taking call.

Many members of the board are actively approaching colleagues about serving on a committee or assisting in one of our efforts. Membership in our college among NC emergency physicians continues to rise. As a result, we will have an extra delegate to the ACEP Council meeting this fall. If you know a colleague who is a practicing emergency physician but not a member of ACEP, approach them about membership. **I would encourage each of you to attend our next Board meetings at the Grandover Conference Center in Greensboro on February 2, 2006 or May 4, 2006. Consider attending the June Jam in Myrtle Beach June 9-11.** Please visit our website (your website), feel free to contact any of the Board members about becoming active in your College.

**Best wishes for the New Year!**

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## EDITOR'S NOTE



Jason Hack, MD

The National Report Card on the State of Emergency Medicine *Evaluating the Environment of Emergency Care Systems State by State* is now

available ([www.acep.org](http://www.acep.org)). While anything I receive that says "report card" immediately brings up my defensive hackles, after reading the report, I realized its goal and usefulness and this is why I would suggest that every emergency physician read it. It is the first large scale attempt to orient politicians and the lay public about the hole that emergency services has fallen into. This report card will serve as a baseline for a series of planned evaluations to show if changes are indeed enacted.

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### NC EPIC

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I know you are busy, so here is my summary book report. It was an evaluation of 50 objective and quantifiable criteria grouped into four categories and graded. These grades were "not evaluations of physicians or hospital emergency departments", but instead were to show, in a way that anyone can understand, the overall effort of states to support effective emergency systems.

The stated objective of this report was "to motivate state and national policy support for improving emergency care." The categories included **Access to Emergency Care** (measured emergency resources in the state, state health care spending, what percentage of a state's population is uninsured, the number of hospital-staffed beds.) This category was valued highest because a states' access is a critical measure of commitment to the emergency care needs of its residents. [C-]; **Quality and Patient Safety** (measured state support for training emergency physicians and EMS personnel, patient access to ambulances and 911 services, and if the state measured ambulance diversion) [C]; **Public Health and Injury Prevention** (measured state support for health and safety programs—seat belt, helmet, and drunk driving laws, percentage of the population that is immunized, the presence of emergency preparedness programs, and public health programs promoting safer environments.) [B+]; **Medical Liability Environment** (measured increases in state medical liability rates and state support for medical liability) [F]. The state failed because "despite state's physicians and specialists seeing dramatic increases in their medical liability insurance rates (2001-2004: 74.83%, North Carolina has done nothing to address the problem." Our overall score was C-, ranking us 36th in the nation with California first and Arkansas last. More than 80% of states earned poor overall grades (C+ to D).

The report emphasizes that the system is under extreme stress with increasing emergency department visits to nearly

114 million in 2003 (the highest ever) while the overall capacity of the nation's emergency systems has decreased, with the number of EDs decreasing by 14 percent over the last 13 years.

The report concludes with recommendations for North Carolina: to attract more board-certified emergency physicians; build more emergency medicine facilities; provide residents with greater access to safety services; enact a \$250,000 cap on non-economic damages for medical liability lawsuits, which will help in its efforts to attract more physicians.

While perhaps not definitive, it does lay down the groundwork to begin a dialogue about the crisis that we find our patients and ourselves in.

This report has made understandable the crisis that emergency medicine is in both at the national level and within our state. Hopefully its dissemination convinces and pressures policymakers, physicians, and the general public to initiate changes. We must heed these findings or we will all suffer.



**SAVE THE DATE!**

**17TH ANNUAL**

**JUNE JAM**

**June 9-11, 2006**

**Embassy Suites  
at Kingston Plantation  
Myrtle Beach,  
South Carolina**

# REIMBURSEMENT COMMITTEE REPORT

January 2006

Charles A. Bregier Jr, MD, FACEP  
Chair, NCCEP Reimbursement Committee

## Section 1011 Update

At the time of this writing, 57 hospitals in North Carolina have enrolled in the MMA mandated *Federal Reimbursement of Emergency Health Services Provided to Undocumented Aliens* being administered by Trailblazer Health Enterprises, LLC. Trailblazer has updated their website with helpful information. The link is <https://www.trailblazerhealth.com/Section 1011>: the Q&A tab breaks the information down into digestible pieces. EM groups and their billing companies need to be very familiar with the details of this new plan.

### A couple of noteworthy points:

- 1) This is a payer of last resort; you must have attempted to collect from every other payer and have attempted to bill the patient before you can submit a 1011 claim, and
- 2) If your hospital is seeking reimbursement using the “roster” method, they are authorized to collect for you (meaning that you cannot submit your own claims). Most enrolled hospitals have not used the roster method.

Granted, there are many hoops to jump through to enroll. But we are between a rock and a hard place. The feds are finally offering us some financial relief resulting from the EMTALA burden, and we need to step up and get our piece of this pie. Those who sign up the soonest will probably benefit the most as future payments will probably get smaller as the numerator (\$ available quarterly) will remain constant as the denominator (all submitted charges for the corresponding quarter) grows. The bottom line: we can't be complaining about the EMTALA mandate if we don't run with this bone.

## Reimbursement Committee Expansion

The committee has been expanded to a total of six members. New NCCEP committee members include Frank Smeeks, Nizar Ghuneim and Otto Rogers. We have also added two ex-officio members, Ed Gaines and Michael Brohawn. Ed Gaines is Senior Vice

President and General Counsel for Healthcare Business Resources in Raleigh. Michael Brohawn is the Practice Administrator for Wake Emergency Physicians, PA. The financial and business background of all our new committee members is very strong. The purpose of the expansion is to expand the scope of reimbursement issues and develop a prioritized timeline to address them. The expansion gives us better resources to work on these issues. We invite each of you to let us know what reimbursement items would best benefit your group to help in this endeavor.

## Moderate Sedation

The codes for moderate sedation have been changed for 2006, as well as the terminology: from “conscious sedation” to “moderate sedation”. Starting January 1, codes 99141-99142 are gone. They have been replaced by codes 99143-99150, which are time based and age specific (over or under age 5). CPT has identified what procedure codes *cannot* have moderate sedation codes billed separately with the procedure codes (if moderate sedation was provided, it is bundled with the procedure).

We all know that Medicare and many other payors won't reimburse for moderate sedation. But there may be light at the end of this tunnel. Although CMS has assigned zero RVU's to these new codes, they have also said that these codes will be “carrier priced”. This may allow for reimbursement from some carriers in the future.

Clearly, a policy change that results in Cigna Medicare reimbursing us for these important (medically indicated) services is overdue, and could have great financial impact on our practices. The Reimbursement Committee will work diligently to try to achieve this as one of the important goals described above.

*Dr. Bregier is a member of NCCEP's Board of Directors, Chair of the Reimbursement Committee, and NCCEP's representative to the Cigna Medicare Carrier Advisory Committee. He has been practicing Emergency Medicine and Urgent Care in Charlotte since 1987. He is currently employed at Presbyterian Urgent Care. Please contact him at [cbregier@carolina.rr.com](mailto:cbregier@carolina.rr.com) for any reimbursement related questions or issues that you would like addressed.*

# AN ED TOOL KIT FOR MANAGED CARE NEGOTIATIONS — PART 2

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**“If you don’t ask, then the answer is always ‘No’ ”!**<sup>1</sup>

**Part 2 of our discussion on negotiating ED managed care contracts should not be taken as any less significant, nor any less important than Part 1.**

Remember the words above; you have to ask for things in these contracts. It is a very common and quite natural experience for ED physicians to back off in negotiations when they have settled on the numbers (i.e. settled on reimbursement rates). It is imperative to realize this can be very problematic for a practice, as there are many contingencies in these contracts that can seriously damage a practice, if not properly addressed in the negotiation process. Remember, these contracts are typically not written for ED practices, and must be specifically tailored to ED specific issues.

**Why? The ED practice may have to “live with” these terms for years.** More importantly, the local network administrator with whom the group is negotiating may not know that their health plan has agreed in formal legal settlements not to include certain provisions in their contracts. It may sound strange that everyone in the health plan may not know what their employer is legally bound to “not do” in future contracts—but based on provisions and payment practices we’ve seen from these health plans our initial take is —

## Not Everyone Got The Memo !!!

In this article we will discuss the following important issues to be addressed in these contracts:

1. Claim Submission Parameters
2. Payment Parameters
3. Hold Harmless Restrictions
4. Enrollment/Credentialing Timeframes
5. Assignment Issues: Contract and Patient Parameters
6. Amendments
7. Indemnification
8. Term and Termination
9. Legal Review

## 1. CLAIM SUBMISSION PARAMETERS

Every contract will restrict a practice’s window for submitting claims. Today, most payers are constricting these days more and more (i.e. 90, 60, 45, or even 30 days). This is a clear example where contracts are written more in line with other specialties, particularly primary care practices, whose patients virtually always have their insurance information at the time of visit, or routinely provide it very timely after their visit. This is simply not the case in EDs, where patients commonly present without their insurance information, and frequently ignore ED bills, even risking going into collection, and their credit status. It is wise to have as wide a window as

possible; our recommendation is a full year (365 days). You never want to go below 180 days. Remember the issue here is if you exceed the window, you will be forced to either write off claims, or at best appeal the rejections, which can be very burdensome, time consuming, and costly, but more significantly, it causes cash flow problems.

Also, enrollment and credentialing may have an impact on your claim submission requirements. Certain health plans, e.g. Blue Cross/Blue Shield, may refuse to “back-date” the participation date of the provider, and/or group. This results in the “Hobson’s Choice” of submitting non-par claims where the reimbursement is mailed to the patient or “holding” the claims until the participation and contracting are finalized. In the latter example, the claim submission requirements in the agreement should be written to “carve out” claims that are on hold pending the enrollment and participation status of the providers. If the non-par claims are released, then the reimbursements are usually mailed to the patients and the “race is on” to collect those payments from the patients.

## 2. PAYMENT PARAMETERS

The AMA<sup>2</sup> reports today that 49 states and the District of Columbia have prompt-pay statutes, so take advantage of them! Always mirror your state’s statutes in your contracts, and don’t assume the payer will graciously include it. Although these statutes exist, be assured they also have their own contingencies, namely that claims be “clean”, which can be a vague definition. Very importantly, in addition to payment timeframes, you want to secure electronic claim submission, and importantly electronic remittances. The latter makes life much easier for your A/R staff.

If the health plan is one of those that has settled in the HMO class action settlements — please refer to the [www.hmosettlements.com](http://www.hmosettlements.com)<sup>3</sup> website for additional information, e.g. Aetna, Cigna, HealthNet, Wellpoint/Anthem and Humana (as of 12/2005) — then the health plan is obligated to allow the provider to avail itself of greater protections offered under the prompt pay laws if those state laws are more protective to the provider than the terms offered by the health plan (almost always the case).

## 3. HOLD HARMLESS RESTRICTIONS

Here we have a section in contracts that can severely limit who can be billed, specifically laying down restrictions on patient billing. The first thing to insure is this section can only be applied to “covered services”. We recommend you reserve your right to appeal claims, and if necessary, bill patients for claims that are adjudicated as being noncovered, non-emergent, or not medically necessary. As noted above, if the health plan will not

make the participation status retroactive to the earliest service date, and the nonpar claims are released, the ED group must have the right to bill and collect directly from the patient. We make the assumption that your practice is only providing medically necessary services, and you therefore need to protect your practice from questionable protocols of payers, that deny claims after-the-fact. **A good phrase to add to hold harmless clauses is as follows:**

***“...This provision does not prohibit, nor limit the physician, hospital from any appeal process, nor the collection of co-pays, deductibles, co-insurance, or payments from patients for services deemed to be non-covered, not an emergency, or not medically necessary and/or non-participating claims where the reimbursement is mailed to the patient and not the ED group. Additionally, the patient can be billed if benefits are exhausted, or the payer defaults on payments...”***

It is very common for payers to justify very restrictive hold harmless clauses based on “regulatory or statutory” reasons that may, or may not be real. Whenever you encounter this justification, always request seeing the legal reference, and get the reference in writing. We have even seen “hold harmless” clauses where the health plan declares Chapter 11 bankruptcy and the group is forbidden from billing the patient for unreimbursed services!

#### **4. ENROLLMENT / CREDENTIALING TIMEFRAMES**

There are many issues that can cause financial damage to a practice, and this one is no exception. Some of this turns out to actually be practice based, while the rest is payer based. Let’s look at these issues.

One point that every physician needs to be careful of is that it is always the physician’s responsibility to notify payers of their practice arrangements, inclusive of moving from practice to practice. From an ED Director’s perspective therefore it is crucial to know about any contracts already in place for your physicians; this is obviously most important for new physicians, and can frequently arise with part-timers. Noted below is a particularly dangerous, but nonetheless real contract provision that caused one practice many, many problems:

***“...This agreement applies to you and the services you provide in all of your practice arrangements and for all of your tax identification numbers, except that if your services are covered under an agreement between us and a medical group that you are a part of, services that you provide through that medical group will be subject to that other agreement and not this agreement...”***

Another example:

***“...These rates apply to all current and future locations billed under this and future Tax Identification Numbers indicated by Provider through a signed W-9 form and subject to terms of this Agreement...”***

The problem that arose in the first instance was the ED group had no contract, but some of the physicians had private agreements that the payer considered binding, across all their practice sites. These clauses are traps, and must be recognized, and deleted.

Of critical importance now is to inquire, review, and clearly understand how long your staff will take to pull together payer enrollment documents, and very importantly, to get a commitment from the payer on their turnaround times. Issues to be discussed include whether you can submit claims while your physicians are being credentialed, can non-par provider numbers be given, and ultimately how will your practice be paid during the enrollment/credentialing process. If you are forced to hold claims, this issue has the potential to cause very significant cash flow problems. Lastly, it is a common tactic that payers will attempt to restrict physicians from even seeing their patients, unless a contract is in place; needless to say, this cannot be implemented in the ED.

Again the HMO class action settlement provisions may be helpful here at least to provide an outer limit to the time period that the health plan must complete credentialing of the providers. For example, consider Section 7.13 of the Aetna, Cigna, HealthNet, Wellpoint/Anthem and Humana settlement agreements (“the HMO Settlement Agreements”):

***“New physician group members will be generally credentialed within 90 days of application, which physician groups can submit prior to their employment, and little or no additional credentialing will be required when already credentialed physicians change employment or location.”***

We recommend that you do not assume that all of the settling HMOs have updated their agreements for full compliance with the HMO Settlement Agreements. These health plans may not have provided comprehensive training to all of their networking representatives regarding terms and conditions of the HMO Settlement Agreements.

#### **5. ASSIGNMENT ISSUES-CONTRACT AND PATIENT PARAMETERS**

Assignment clauses are frequently written unilaterally, allowing the payor to assign or sell the contract, participating provider list and/or network fee schedule to other plans, even future plans, and entities. When written by the health plan, the right to sell or assign is unlimited and can be exercised without the prior knowledge or approval of the ED group. This can certainly lay the foundation for what has become known as the Silent PPO phenomenon. Silent PPOs are PPOs with whom the ED group has no contractual relationship, but have purchased the participating provider lists and fee schedules from PPOs in which the ED group does participate. When the member of the Silent PPO is treated by the ED group provider, the Silent PPO considers such treatment to be “in network” and reimburses the group at the network discounted rate instead of the provider’s charges.

It is imperative to never allow assignment without a review period of at least 60 days, with the provision allowing the practice to veto the assignment, and terminate the contract, if necessary. Sample wording to be careful of is as follows:

***“...ABC Company may assign, delegate, or transfer this agreement in whole, or in part to any affiliate, existing now or in the future, or to any entity which succeeds to the applicable portion of its business through a sale, merger, or other transaction....”***

When any contract is negotiated, a critical part of the process is to assess the past, and current patient volume, as well as other indices (i.e. acuties, rates, etc.), and know this data for every plan involved. A practice must know what it is getting itself into with every contract, and cannot afford to have additional plans rolled into deals via this method, without a separate analysis, and opportunity to refuse the new plan addition(s), without a review period. The concept of a Silent PPO is based on payers adding plans to existent contracts, through assignments, mergers, acquisitions, and/or actual selling of their participating provider lists. You want protection against these practices; refusing to accept open-ended assignment clauses is one way of doing this.

A current issue that is playing out today in contracts and in the courts is the issue of patient assignment of benefits. These are statements signed by most ED patients at the point of registration, where they effectively “assign”, or turn over their insurance payment to the provider of service (i.e. hospital, physician). When a practice has no contract, some payers today are now directing their payments to the patients, despite the existence of assignment of benefits “contracts” between providers and patients. This is a very current issue, and a protocol you need to be aware of as you evaluate the pros and cons of contracting. If you are in a situation of not being satisfied with rates, and/or other contract contingencies, this threat to pay patients can become very difficult to counter. Payments sent to patients can be very difficult to collect.

There is “good news” and “bad news” on the assignment of benefits (AOB) issue regarding the HMO Settlement Agreements. First, Sections 7.15 of the Aetna, Cigna, HealthNet and Humana agreements all contain similar AOB provisions as follows:

**Assignment of Benefits Accepted. Health Plan will recognize an assignment of benefits, subject to certain conditions.**

As Ross Perot was fond of saying during his presidential campaign, “the devil is in the details.” The “subject to certain conditions” provision noted above may allow the health plan to not honor the patients’ AOB if other competing health plans in that particular market would not honor the AOB. This “exception” may, therefore, swallow the rule and permit the plan from not honoring the patient’s valid AOB. Finally, please note the list of health plans above with Section 7.15 does not include

Anthem/Wellpoint (both former Blue Cross/Blue Shield plans) as these plans did not even include the provision above in their settlement agreements — thus there is simply no settlement restriction on Anthem/Wellpoint from the AOB perspective.

## 6. AMENDMENTS

An absolute here is to insist on a review period of at least 60 days, allowing your practice to evaluate any potential contract change, and very importantly that these amendments be sent via certified mail to a specific senior person in the practice. These are clauses allowing contracts to be changed, much like the assignment provisions noted above.

## 7. INDEMNIFICATION

It is very common for these clauses to be one-sided in favor of the payor. It is imperative they be re-written to be mutual, preserving both parties’ interests.

## 8. TERM AND TERMINATION

Here’s a sample you don’t want:

***“...This agreement shall commence on the effective date and, shall continue for an initial term of four (4) years and shall thereafter automatically renew for successive one (1) year periods, unless written notice of non-renewal is given to the other party at least one hundred eighty (180) days prior to the end of the then-current term...”***

We suggest 4 years is simply too long, as the current healthcare environment is constantly in flux, with mergers, collapses, and new companies coming on the scene every day. Additionally, the patient mix can dramatically change, especially if additional plans are added, etc., etc. Very importantly in this sample section is the fact a 180 day notice is required, but it is also required 180 days ahead of the next anniversary date. If you happen to have serious problems that are prompting you to even consider termination, but you just passed the anniversary date, you may have to wait a whole year before terminating the deal, other things being considered here. This is clearly a position you don’t want to be in at any time!

## 9. LEGAL REVIEW

Whenever you negotiate a contract always understand you are up against the best attorneys the payor has to offer, so never sign a deal without your attorney reviewing it too. It is simply a matter of protection; don’t overlook it.

Moreover, the HMO Settlement Agreement provisions noted above should be reviewed by experienced, competent health care counsel in the context of your group’s particular agreement. While the information above is solely informational and not intended as legal advice, these Settlement Agreements have time period restrictions and limitations.

### References

1. Croce, Pat. I Feel Great and You Will Too. Running Press Book Publishers. Philadelphia. 2000.
2. American Medical Association, website reference, 2005.
3. www.hmosettlements.com

**TO:** NCCEP Members  
**FROM:** Colleen Kochanek, NCCEP Legislative Counsel  
**RE:** Emergency Physician PAC

We are excited to report that the Emergency Physician Political Action Committee (EP-PAC) has been created and approved by the North Carolina College of Emergency Physicians Board of Directors and is now operating. We are officially requesting donations from members and all others who are interested in furthering the interests of Emergency Physicians in North Carolina.

**Some basic legal requirements should be remembered:**

- Only INDIVIDUALS may contribute to a PAC. (No corporations or professional associations)
- Contributions are limited to \$4,000.00 per individual per election cycle
- Information must be obtained from donors over \$100.00, including name, address and occupational information
- Contributions include donated items for fundraisers and other goods and services

Beginning next year, we will request PAC contributions along with the dues statement from the American College of Emergency Physicians. In order to get the PAC going, however, we are requesting donations immediately so that we can use the funds to assist the College in fighting for Professional Liability Reform, Assignment of Benefits Issues and other issues facing Emergency Physicians on a regular basis.

**We will list all donations to the EP-PAC in the EPIC and encourage all members to participate. The donation levels are as follows:**

**BRONZE:** 0 - \$250  
**SILVER:** \$251 - \$500  
**GOLD:** \$501 - \$999  
**PLATINUM:** \$1,000 and over

**Thank you in advance for your generous contribution!**

----- Detach and Return -----

**Please complete and return with your Personal check to:**

**EP-PAC  
P. O. Box 2060  
Raleigh, NC 27602**

**Phone: 919-420-7826**

- Bronze** \$ 0 - \$250
- Silver** \$251 - \$500
- Gold** \$501 - \$999
- Platinum** \$1,000 and over
- Personal Check Enclosed.**

*(Please print)*

Name \_\_\_\_\_

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City/State/Zip \_\_\_\_\_

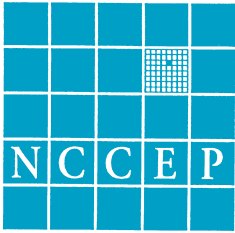
\*Job Title or Profession \_\_\_\_\_

\*Name of Employer or Employer's Specific Field \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_\_) \_\_\_\_\_

**\*North Carolina law requires political committees to report the name, mailing address, job title or profession and name of employer or employer's specific field for each individual whose contributions aggregate is in excess of \$100 in an election.**

**NOTE:** Contributions to EP-PAC must be written on personal checks; corporate and professional checks are not acceptable. Contributions to EP-PAC are not deductible as charitable contributions for federal income tax purposes. All contributions to a PAC are a matter of public record, as are the PAC's contributions to specific candidates. Contributions to EP-PAC are strictly voluntary, and you have the right to refuse to contribute without any reprisal.



North Carolina  
College of  
Emergency  
Physicians

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## DATES TO REMEMBER

**NCCEP Board Meeting**

**February 2, 2006**

Grandover Conference Center  
Greensboro, NC

**NCCEP Board Meeting**

**May 4, 2006**

Grandover Conference Center  
Greensboro, NC

**ACEP Leadership Conference**

**May 21-24, 2006**

Washington, DC

**NCCEP June Jam 2006**

**June 9-11, 2006**

Embassy Suites at Kingston Plantation  
Myrtle Beach, SC

**ACEP 2006 Scientific Assembly**

**October 15-18, 2006**

New Orleans, LA