PRESIDENT’S MESSAGE

NJ Chapter activity during recent months included an informative spring Socio Economic Meeting, attendance at the 4th annual Joint Surgical Advocacy Conference in Washington DC, and this year’s Pilgrimage to London, England.

The spring Socio Economic Meeting was targeted toward one aspect of the Affordable Care Act—the provisions encouraging formation of Accountable Care Organizations. Our diverse panel highlighted the opinions of Physicians and Lawyers from New Jersey and a thoughtful Louisiana surgeon known for representing the interests of the American College of Surgeons in our nation’s capital. The debate was animated since the participants were by no means in agreement on the future of health care. The lunch session featured NJ Assemblyman Herb Conaway, MD and Senator Jennifer Beck. Your NJ-ACS Council convened following the educational session. Since attendance at these meetings was rather sparse, the majority of our fellows and councilors will find a more detailed summary of the proceedings provided by Dr. Chamberlain on page eight.

The New Jersey Chapter joined many of the other state chapters and surgical specialty societies for the purpose of advancing issues of particular importance to the surgical community. The Joint Surgical Advocacy Conference (JSAC) is conducted in conjunction with the ACS Leadership Conference and is focused upon the substance of and methodology for influencing healthcare policy at the national level. For neophytes, the first half day was focused upon the stark realities of the legislative process and the potential to influence its outcome. The afternoon session featured our Washington ACS staff who are well versed in this process. They provided a précis of major common issues and current proposed legislation appropriate for unified advocacy. Surgeons who are also members of Congress offered their unique perspective; they were Dan Benishek (R-MI), Larry Buchshon (R-IN), and Andy Harris (R-MD). Scheduled appointments with the appropriate Senators and Representatives were arranged for each delegate on the following day. After transporting us to Capitol Hill, we discussed these issues and advocated on your behalf in the offices of Senators Lautenberg and Menendez, and our individual Congressmen. It was painfully clear that the presence and amplitude of Surgical Advocacy in Washington is scarce in comparison to other influential lobbyists who also work with our patients, such as the Pharmaceutical, Hospital, Insurance, and Legal organizations. This was an entirely enjoyable experience, and is available to all members of our Chapter; more participation is encouraged to accompany the state officers in our delegation next year.

Yours in Fellowship,

Frank T. Padberg, Jr., M.D., FACS, President
STUDENT LOAN REPAYMENT PROGRAM

Your New Jersey Chapter proudly announces the Student Loan Repayment Program. The program, the brain child of Dr. Michael Goldfarb, was developed to facilitate the recruitment and retention of highly qualified general surgeons to serve in underserved areas of New Jersey. Through the auspices of Building Hope and Sallie Mae, a total of $50,000 per year over two years will be awarded to a qualifying surgeon. The criteria is as follows:

a) Eligible debt includes all qualifying student loans that are outstanding at the time of application;

b) Qualifying hospitals is a hospital approved by New Jersey Chapter, American College of Surgeons;

c) Qualifying surgeon is a surgeon who is out of a residency program for less than five years and who at a minimum holds a current (permanent and unrestricted) New Jersey license and who is either a United States citizen, a United States National or a lawful permanent United States resident;

d) Employment responsibilities: The surgeon agrees to work as a surgeon for a minimum of two years in a qualifying hospital or medical practice. Should the surgeon not meet this obligation, the monies already paid will be re-paid by the surgeon.

The American College of Surgeons is looking into a similar program.

A special thank you goes to Dr. Goldfarb and his Committee for their dedication and hard work on this project. The Committee members are Drs. Alexander, Carniol, Chamberlain, Fletcher, Moritz, Padberg, Rough and Wetstein.

For more information about the program, please call the Chapter office.
ACO’s and the New Jersey Surgeon: All you Need to Know But Are Afraid to Ask”

Those of you who missed the Annual Socio-Economic Meeting of the NJ Chapter of the American College of Surgeons on Saturday, March 12, 2011, missed one of the most informative, entertaining, and important meetings of the year. The meeting was headlined by Dr. Frances Opelka, MD (Associate Dean for Healthcare Quality and Safety, Professor of Colorectal Surgery, Louisiana State University). Dr. Opelka stressed that these are turbulent times for health care as we face out of control costs, an aging population, and an unprecedented increase in lifestyle-associated diseases. These issues are compounded by unrealistic health care expectations by most Americans who expect “everything for everyone,” despite no clear solution as to who is going to pay. Congressional efforts to address these issues have led to a confusing pathway of legislation and regulations culminating in the latest model for health care organizations called the Accountable Care Organization (ACO). Whether this will represent a new transformational model, or is the “same old wine in a brand new bottle” is unclear? What is clear to Dr. Opelka and the other speakers is the fact that surgeons need to be involved in the process and the decision making. It is no longer possible to simply say we deliver the best surgical care. We have to prove it! This process will involve getting leaner and meaner in every aspect of care we provide — and at the same time, maintaining excellent levels of patient satisfaction. We can’t accomplish this unless we are stakeholders involved in the very honest and strategic discussions about which services we offer. We can WIN the game but it will require us to:

1. Embrace data transparency
2. Insist on evidence-based practices in all we do
3. Ready ourselves, our groups or our organization for pay for performance

Though challenging, these are not impossible goals—and they will apply to whatever model the State and the country ultimately choose. ACOs may not be the magic bullet, but they are coming and we must be involved with shaping how surgical practice will be reflected within them.

The second speaker was attorney Robert J. Conroy, of Kern Augustine Conroy Schoppmann, who is co-counsel on a case seeking to declare the Patient Protection and Affordable Care Act unconstitutional. The case is currently pending before the 3rd Circuit Court of Appeals. Like similar legal actions from other Attorneys General, the legislation challenges the enactment of a federal statute which mandates that a substantial number of American citizens purchase a product, health insurance coverage, or suffer a penalty for failure to do so. The case argues that Congress sought to illegally exercise its power (under the Commerce Clause) to force individual citizens to purchase goods or services. It further seeks immediate court relief since this is an issue which directly and profoundly affects virtually every citizen of this nation. This was followed by a lively discussion, and there was considerable debate among the speakers and the audience about the ultimate success of these legal proceedings.

The final speaker was Donald Casey, MD, the current Vice President for Quality and Chief Medical Officer for Atlantic Health. Dr. Casey drew on his considerable experience on the local, State and National stage to review for us the importance of surgical leadership in the healthcare quality revolution. He stressed the fact that this is an issue we can no longer ignore, by noting that our performance is already being measured on many fronts (e.g., SCIP, readmission rates, and complications) and that increasingly it will be tied to financial incentives. The meeting concluded with lunch and comments by two strong physician and patient advocates, Senator Jennifer Beck (R – NJ), and Assemblyman Herb Conaway (D-NJ). These NJ politicians brought exciting news about progress in tort reform, malpractice, and “good Samaritan” legislation.

I strongly encourage all NJ surgeons to be attentive and get involved in shaping the health care debate which rages around us. When you do nothing, you feel overwhelmed and powerless. But when you get involved, you feel the sense of hope and accomplishment that comes from knowing you are working to make things better.

Ronald S. Chamberlain, MD, MPA, FACS
President-elect

Ronald S. Chamberlain, M.D.
The American College of Surgeons Division of Advocacy and Health Policy continues to focus on four major themes as defined by the ACS Health Policy and Advocacy Group. The four areas are:

1. Quality;
2. Physician Payment;
3. Workforce;
4. Medical Liability Reform

**Quality**

The ACS team in Washington continues to work closely with the larger team for the American College of Surgeons on the ACS Inspiring Quality Campaign. If you haven’t seen the information on this campaign including the video (which is very well done) then I urge you to check it out .... http://www.facs.org/quality/index.html We have a great story to tell about how improving quality of care can lead to cost reductions – the ACS is THE leader in this effort.

The ACS signed onto the Partnership for Patients campaign along with many of the major physician, hospitals, employer and health plan groups. The goal of the campaign is that by 2013 – hospital-acquired conditions are decreased by 40% and all hospital readmissions would be reduced by 20%.

There are some concerning issues going on under the heading of quality.... The penalties regarding e-prescribing and electronic health records are unreasonable for many reasons. Additionally, some in Congress are calling for an unreasonable amount of information to be shared publicly regarding physicians and physician practices. While the College continues to be the leader on quality issues, we continue to fight against irrational efforts that hide behind the quality banner.

One last note, if you are looking for a very good policy brief on the quality movement (which is better described as health system redesign) then I would encourage you to check out a new health policy brief developed by Robert Wood Johnson Foundation and Health Affairs ... http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=45

**Physician Payment**

The College is actively working this effort on multiple fronts:

- In the past ten years, Democrats and Republicans in Congress have created a large debt related to the Medicare physician payment issue. They stop the cuts each year, but they pay the minimum on the credit card bill and wonder why the credit card bill on Medicare physician payment is now $350+ billion. How does Congress get out of this debt? Whatever they do .... Don’t blame the doctors. We believe that quality improvements which lead to cost reductions can help some.
- Once the debt is paid, what will this broken SGR system be replaced with? The College is helping to lead the efforts by bringing together some of the best and the brightest in this area to help develop new models. The health care reform law (whether you love it or hate it) created some options to test in this area (accountable care organizations, bundling, etc...), but we need to look at every possible option and surgeons need to be leaders in these efforts.
- As we work on these fronts, we continue to urge Congress to ensure that surgeons are paid appropriately under the present system or any new system. The 30+% cut scheduled for January 1st needs to be stopped. A few years of stability is absolutely necessary.
- The proposed regulations (rules) related to Accountable Care Organizations are out and the ACS will be providing substantial comments to the Centers for Medicare and Medicaid Services. Once again, the key is going to be for surgeons to lead.

**Workforce**

ACS leaders are keenly aware of the fact that the surgical workforce is impacted greatly by a host of issues – physician payment, medical liability reform, quality of care efforts, etc....

Two specific campaigns ---- The ACS was successful in getting included in the health care reform law a 10% bonus payment for surgeons working in rural areas. We are now facing the problem that this section of the law is not being implemented correctly and the appropriate surgeons are not getting the bonus. We are working aggressively to get this fixed.

In addition, we are also working to get the law changed so that surgeons, rather than just primary care physicians, can see some loan forgiveness when agreeing to practice in rural underserved areas.

**Medical Liability Reform**

The ACS continues to support traditional medical liability reform that includes the $250,000 cap on non-economic damages. We have indicated our support for HR 5 (strong medical liability reform) in the House of Representatives. We also continue to support medical liability reform efforts at the state level as well.

We are also working to evaluate some alternatives to traditional medical liability reform. We are hopeful that we will have more to share on this issue soon.

Christian Shalgian, Director, Division of Advocacy & Health Policy
American College of Surgeons
202-672-1504
chshalgian@facs.org
ACCOUNTABLE CARE ORGANIZATIONS – “FACTS AND FICTION”

Since the passage of the Patient Protection and Affordable Care Act of 2010 (PPACA) brought about the introduction of a previously heretofore unheard of concept known as an “accountable care organizations” (ACOs), there has been a growing conversation in the medical community centered around two primary questions – what are ACO’s and what do they foretell as to the future of medicine? ACOs were introduced as a Medicare savings program, intended to enhance quality, improve beneficiary outcomes and increase the value of care through incentives to healthcare providers. Although PPACA mandates that the federal government establish an ACO-based Medicare shared savings program by January 1, 2012, at this juncture there has been little guidance issued by the federal government with respect to these ACOs and how they will be structured.

In fact, until regulations are finally issued many months from now, it is unlikely that ACOs will truly impact the Medicare fee-for-service system in the near future. Parsing through the rhetoric and alarmism, it is important for physicians to understand that although many new ideas have been proposed with respect to Medicare (ACO’s only being one of them), at this time, physicians are in no way precluded from continuing to care for Medicare patients even if they are not currently associated with an ACO. As such, physicians should be cautious and take this period of flux to truly understand and evaluate the risks and costs associated with ACOs prior to joining one or providing capitalization to an entity (i.e., an IPA) that may never even qualify to serve as an ACO.

This is not to say that ACOs will not have their place in the future delivery of healthcare in America. Already, many commercial health plans are collaborating with physician groups and hospitals to form ACOs to improve the quality of care provided to their members and, moreover find innovative ways to decrease medical costs. Medicaid programs across the country are forming ACO demonstration projects for the same purpose. However, until the regulations for Medicare ACOs are finalized, Medicare fee-for-service will continue.

What is an ACO?

An ACO is a group of providers or a network of groups, which may or may not be affiliated with a hospital, which agrees to be “accountable” for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program (as opposed to an HMO in which the “accountability” rests with the insurer instead of the providers). In the event that the ACO is able to provide care at a lower cost than Medicare did in the prior period, and assuming that the ACO meets the quality standards set by Medicare for the ACO, the savings will be shared with the ACO. Once again, physicians should take note – the specific quality performance standards which an ACO will have to meet have yet to be determined.

What requirements must be met to be an ACO?

As per PPACA, in order to participate as an ACO, the ACO must meet the following requirements: (1) Have a formal legal structure to receive and distribute shared savings; (2) Have a sufficient number of primary care professionals for the number of assigned beneficiaries (to be 5,000 at a minimum); (3) Agree to participate in the program for not less than a 3 year period; (4) Have sufficient information regarding participating ACO health care professionals as the Secretary of the Department of Health and Human Services (HHS) determines necessary to support beneficiary assignment and for the determination of payments for shared savings; (5) Have a leadership and management structure that includes clinical and administrative systems; (6) Have defined processes to (a) promote evidenced-based medicine, (b) report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx), and Electronic Health Records (EHR), and (c) coordinate care; and (7) Demonstrate that it meets patient-centeredness criteria, as determined by the Secretary of HHS.

Furthermore, the statute lists the forms of organizations that may become eligible to participate as an ACO which are as follows: (1) Physicians and other professionals in group practices; (2) Physicians and other professionals in networks of practices; (3) Partnerships or joint venture arrangements between hospitals and physicians/professionals; (4) Hospitals employing physicians/professionals; (5) Other forms that the Secretary of HHS may determine appropriate. Therefore, before any physician joins forces with an ACO, it is imperative that he or she evaluates and understands the implications associated with the different models. For instance, in the event a physician joins an ACO in which a hospital employs the involved physicians, the joining physician needs to understand that he or she will be giving up his or her autonomy and will serve the ACO strictly as an employee of the hospital. As a result, physicians contemplating retirement and/or physicians who are no longer interested in the stress of running a practice may see this as a viable option, however, physicians with a more entrepreneurial perspective may well find the hospital ACO too limiting – both financially and professionally.

Moreover, primary care physicians should pay particular attention to contracts that could bind them to an ACO. Although the regulations for ACOs are not yet published, it is anticipated that patients will be attributed or assigned to an ACO through the primary care physician. Hence, a primary care physician can only belong to one ACO. Unlike Medicare Advantage plans wherein individual patients elect to join a specific Medicare Advantage plan, once a primary care physician joins an ACO it is anticipated that CMS will require his or her patients to join that ACO or switch physicians.

What are the legal implications associated with ACOs?

As noted above, the Department of Health and Human Services (HHS) has yet to finally issue any regulations governing ACOs. They have published draft regulations for comment recently, but it does not anticipate that the final language of such regulations will be published before the end of 2012.

(Continued on Page Six)
Regardless of the eventual specifics, the current statute and draft regulations foretell that the design of an ACO will certainly implicate several critical state and federal rules and regulations, including, but not limited to, federal antitrust laws, and the fraud and abuse laws (stark and anti-kickback). Interestingly, to facilitate the establishment of ACOs, PPACA grants the Secretary of HHS the right to waive certain provisions of the fraud and abuse laws. Since HHS has yet to promulgate final regulations, it is unclear whether the provisions of the fraud and abuse laws will indeed be waived or to what degree. As such, physicians should be extremely cautious with respect to joining an ACO. An improperly created ACO could well expose a physician to potential anti-trust, and fraud and abuse scrutiny.

What are the practical implications involved with joining an ACO?

Although many physicians are rushing to join quasi-ACOs as the result of scare tactics and bad advice, the medical community needs to act with great caution. There are not only significant legal risks but also unprecedented anticipated costs associated with the formation of an ACO. Specifically, even the barest of structures will carry significant capitalization costs, requiring new technologies, sophisticated legal and consulting expertise and advance funding for staff and overhead. Many ACOs are asking the physicians to fund these expenses. When asked to invest, the physician should conduct due diligence to the same level that any investment banker would, with the first step being a business plan with complete financial projections for five years, marketing strategy, contracting strategy, management team, governance structure and market analysis. The business plan should serve as the basis of the due diligence process.

Furthermore, in order to meet the statutory requirements for a “compliant” ACO, physicians will have to truly integrate their practices, both clinically and financially. For many physicians this may be a daunting task and not an attractive option. For other entrepreneurial physicians, this may be an opportunity to innovate and effect how healthcare is delivered. In both instances, compliance is critical since any degree of non-compliance will quickly be revealed in either financial failure or investigative prosecution.

In conclusion, ACOs may offer physicians a means to collaborate, innovate and improve the quality of medicine in America, and share in the financial savings from those efforts. But, the “devil” will be in the details. ACOs are intended to be physician-dependent organizations, as all four of the approved legal entities require physicians, and only two of the four include a hospital. However, just like Physician Hospital Organizations of the past, ACOs will only be as good as their leaders; those in control of governance and decision-making will be critical. Physicians take their time, and investigate and conduct proper due diligence before joining an ACO. There is no urgency with respect to joining an ACO. Final regulations will most likely not be published before the end of 2012. Now is the time, though, for physicians to explore their options and give serious thought to the various alternatives and begin discussions with their colleagues. There will be many ACO options and physicians need to understand how each option will effect their day-to-day practice of medicine, and know the likely legal and financial consequences of each.


Kern Augustine Conroy & Schoppmann, P.C., Attorneys to Health Professionals, www.drlaw.com has offices in New York, New Jersey, Pennsylvania and Illinois. The firm’s practice is solely devoted to the representation of health care professionals. Mssrs. Conroy or Schoppmann can be contacted at 1-800-445-0954 or via email at rconroy@drlaw.com or mschoppmann@drlaw.com.

DO WE HAVE YOUR CORRECT ADDRESS?

Are we sending your mail to the correct address? Have you moved recently? Please notify the Chapter office of any changes in your address, telephone number, fax number or e-mail address.

MEMBERS IN THE NEWS

"Michael Goldfarb, M.D., Vice-President of the NJ Chapter authored the Opinion column in the April 2011 issue of General Surgery News. Entitled, A Novel:concept: Recognizing Surgeon's Successes, the article describes a philosophy of public review and praise for "rescue surgeons" in the context of the busy practice at Monmouth Medical Center. For those who do not receive this publication it can be accessed at "generalsurgerynew.com".

TERMINATION OF THE PHYSICIAN/PATIENT RELATIONSHIP

NJAC 13:35-6.22 requires that physicians notify patients in writing of termination of care no less than thirty days prior to the date of termination. The notification is to be mailed certified mail, return receipt to the last known address of the patient. Physicians are required to provide all necessary emergency care and services including prescriptions.

Physicians are not required to comply with the requirements if the physician/patient relationship has been terminated by the patient or if the physician has discontinued providing services to a particular managed care carrier or HMO in which the patient is enrolled.

Copies of the regulations can be obtained by calling the Chapter office, (973) 539-4000.
SAVE THE DATE!!!!!

60th Annual Clinical Symposium
Saturday, December 3, 2011
The Renaissance Hotel & Conference Center
515 Route One South, Iselin, NJ

Save the date for the 60th Annual Clinical Symposium to take place Saturday, December 3, 2011. A minimum of 7.5 Category 1 CME credits will be available. Sessions in general surgery, otolaryngology, plastic surgery, surgical oncology, urology, vascular surgery, cardio thoracic surgery, bariatric surgery, colorectal surgery, ophthalmology and trauma surgery will be included. Also included will be the Sheen Award recipient lecture, surgical jeopardy and presentation of the resident papers. Watch your mailbox for the meeting brochure.

We depend on our corporate sponsors to make this event successful. Should you know of a vendor interested in sponsorship, please give them the sponsorship application found on page ten.

CURRENT EVENTS

2011 Socio-Economic Meeting—March 12, 2011
Drs. Lewis Wetstein, Frank Opelka, Frank Padberg, Donald Casey, Robert J. Conroy, Esq and Dr. Mark Moritz

2010 59th Annual Clinical Symposium—December 4, 2010
Trauma Surgery Session
Drs. Ziad C. Siffri, Alicia M. Mohr and Devashish Anjaria

2010 59th Annual Clinical Symposium—December 4, 2010
Cardiothoracic Surgery Session
Drs. Kourosh Asgarian, Justin Sambol and Alex Zapolanski

2011 Socio-Economic Meeting—March 12, 2011
Dr. Ronald Chamberlain, Senator Jennifer Beck, Dr. Frank Padberg and Assemblyman Herb Conaway
**IN MEMORIAM**

**STEPHEN F. LOWRY, M.D.**

1947-2011

NJ, ACS COUNCIL MEMBER

With the passing of Dr. Stephen Lowry, we have all lost a true friend and devoted colleague.

Dr. Lowry’s professional achievements reflect the truly stellar surgeon, researcher and devoted teacher he had become. There are few surgeons who have been recognized for their achievements to the same degree as Steve. He was known internationally as a leading authority in surgical and tumor metabolism, a complex field which he had mastered over four decades.

Steve’s phenomenal research prowess was known to many of us in New Jersey. The author of 225 separate published research papers, and 109 book chapters, countless letters and editorials in dozens of journals, all produced over the short span of 35 years, the topics that he came to understand so well demonstrated a depth and breadth of research interest and novel experimentation that spoke volumes for the upgraded role of the modern surgeon-researcher. His investigations into cancer cachexia and the basic metabolism of tumors and sepsis, have served as the building blocks for dozens of medications that will empower the next generation of surgical scientists. More than anything else, Steve proved that surgeons could not only care for the patient, but could provide the basic understanding of why that patient was sick.

Dr. Lowry has been a Councilor for the New Jersey Chapter for the past three years.

I have known Steve since 1977, and he never allowed any of his success, or the size of his c.v., the titles he had justifiably earned, or the international reputation that he so deserved, to change the humble, devoted surgeon, husband, father and friend to us all, that he had become. We will sorely miss our esteemed colleague, we will miss his kind demeanor, and his respectful counsel, but we will never forget his devotion and contributions to science, mankind and the care of the patient with cancer.

Arnold M. Baskies, MD, FACS

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**E-PRESCRIBING UPDATE**

CMS has proposed significant changes to the e-prescribing penalty program by adding more exemption categories so that physicians are not unfairly penalized for failing to meet the requirements under the 2012 e-prescribing penalty program. Physicians will have to apply for an exemption via a web-portal by October 1, 2011. The comment period for the proposed regulations end July 25. More information will be available after that time.

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**REMINDER**

The following certificates are required to practice medicine in New Jersey.

**NJ State BME**
Mr. William Roeder
Executive Director
P.O.Box 183
Trenton, NJ 08625-0183
(609) 826-7100

**CDS Registration**
Susan Gartland, Chief Drug Control
Department of L& P Safety
P.O. Box 45022, 124 Halsey Street, 7th Floor
Newark, NJ 07101
(973) 504-6545

**County Clerk Registration Certificate**
NJ SBME regulation 45:9.17 requires that you register your license with the County Clerk in the County in which you reside.

**Drug Enforcement Administration**
80 Mulberry Street
Newark, NJ 07102
(973) 273-5063
FAX: (973) 297-4842
(800) 882-9539
www.deadiversion.usdoj.gov
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SPONSORSHIP APPLICATION
60th Annual Clinical Meeting
Saturday, December 3, 2011
THE RENAISSANCE HOTEL & CONFERENCE CENTER
Woodbridge, NJ

Sponsorship Opportunities

☐ **Gold Sponsor – Contribution of $3,500**
Credit for sponsoring all meals provided and AV support. Gold sponsors will be given NJ-ACS website home page recognition and a link to their own website for one year. Acknowledgement of this level will appear in promotional materials, on site signage, and post-meeting communications. Gold sponsors also enjoy all the benefits of Bronze Sponsors (see below) and 4 representatives.

☐ **Silver Sponsor – Contribution of $2,500**
Credit for sponsoring the membership luncheon. Silver sponsors will be given NJ-ACS website home page recognition and a link to their own website for one year. Acknowledgement of this level will appear in promotional materials, on site signage, and post-meeting communications. Silver sponsors also enjoy all the benefits of Bronze Sponsors (see below) and 3 representatives.

☐ **Bronze Sponsor – Contribution of $1,500**
Bronze sponsors will enjoy the following benefits and privileges for 2 representatives:
- One 6’ draped table display area and chairs
- Access to an electrical outlet
- Continental breakfast, morning break and luncheon
- Badges for company representatives
- Registration list of conference attendees

The exhibit hall will be open from 7:30 a.m. until 5:00 p.m.

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