SOCIETY OF CARDIOVASCULAR COMPUTED TOMOGRAPHY

Society of Cardiovascular Computed Tomography

Renewal Application For Verification of Cardiovascular CT Experience LEVEL 3

I. Maintenance of Competence

Level 3*

- 300 cases cumulative over 3 years, Of which, at least 50 cases must be live (Category A) and 50 can be taped (Category A-1) of the 300 cases.
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- 40 hours of Category I CME every 36 months of cardiovascular CT

1) For the 100 cases involving CT data acquisition, 50 cases must be live cases (Category A) and 50 may be taped cases (Category A-1). Each case should identify whether that patient's data was manipulated and reviewed. Accompanying data must include an anonymous patient list for all 100 cases enumerating and identifying the indication and diagnosis for each component of training.

2) Name and contact information (address, phone number, email address) of the program for direct verification of onsite training.

3) This application must be accompanied with payment in full under the following fee schedule:
   a. SCCT members: $250.00
   b. Nonmembers: $450.00

4) A letter of verification of experience from the SCCT will be processed within 8 weeks. Rush verification (2 weeks) can be achieved for an additional administrative fee of $100.00.

An independent organization has been enlisted to process the verification applications. Any unclear information or circumstances requiring further interpretation will be reviewed by a committee of volunteer SCCT members who are experts in the field of cardiovascular CT.

*Budoff MJ, et al. ACCF/AHA Clinical Competency Statement on Cardiac Imaging with Computed Tomography and Magnetic Resonance: A Report of the American College of Cardiology Foundation/American Heart Association/American College of Physicians Task Force on Clinical Competence and Training. *Journal of the American College of Cardiology.* 2005; 46:383-402.

PLEASE TYPE OR PRINT (IN INK) ALL INFORMATION

I hereby make application to the Society of Cardiovascular Computed Tomography for

RENEWAL
Verification of Cardiovascular CT Experience – Level 3

I agree to disqualification from issuance of Verification if any of the statements hereinafter made by me are false or if any of the rules governing this process are violated.

SCCT Member: _____Yes _____No If yes, please supply your member #: _____

1. Name_____ Sex: Male ____ Female ____
   First Middle Last

2. Mailing address_____

   _____
   City State Zip

   Telephone_____ Fax _____ Email _____

   Valid Medical License #: _____State _____

3. Field of certification: ACGME Radiology/Cardiology/Nuclear Medicine _____

   Other (specify) _____ Date: Month_____ Year_____

   Name at time of certification if different from #1 above:_____

   Other specialty board certification: Board_____ Date:_____

   Board_____ Date:_____

4. **Completion of 40 hours of lectures and/or CME credits related to CT in general and/or cardiovascular CT in particular within the last 36 months:**

   Applicant must have earned **40** hours of Category 1 CME credit during the *prior 36-month period*. **Attach copies of CME certificates to application.**

   Name of program_____

   Date(s) of program_____

   ACCME accredited sponsor/site_____

   Location_____

   # Category 1 CME credits earned_____

Name of program_____

Date(s) of program_____

ACCME accredited sponsor/site_____

Location_____

Category 1 CME credits earned_____

Name of program_____

Date(s) of program_____

ACCME accredited sponsor/site_____

Location_____

Category 1 CME credits earned_____

Name of program_____

Date(s) of program_____

ACCME accredited sponsor/site_____

Location_____

Category 1 CME credits earned_____

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5. **Documentation of cardiovascular CT exams (100 Contrast Cardiovascular CT exams):**

Category A and A-1 Cases - 100 contrast CCT cases where the candidate must be **responsible for and/or primary or co-reader of the cardiovascular CT angiography scan, and be involved in the acquisition and interpretation of at least 50 of the cases and 50 may be taped cases**.

Accompanying data must include an anonymous patient list enumerating and identifying the indication and diagnosis for all of the cases.

Signature(s) of Department Head, Imaging Facility Head, Medical Director, or Hospital CEO:

A Department Head, Imaging Facility Head, Medical Director, or hospital CEO signature is required for each institution listed in this section of the application. If the applicant is the Department Head, Imaging Facility Head, or Medical Director, the verification section must be signed by the Chairperson of the Executive Committee of that institution.

Documentation

You may submit letters or other documents (containing the same information as requested on the following pages) signed by a Department Head, Imaging Facility Head, Medical Director, or hospital CEO.

Institution #1:_____

Cases personally interpreted, witnessed, or interactively manipulated by applicant:

_____ # Category A (Contrast CCT Exams – physically present/direct performance)

_____ # Category A-1 (Contrast CCT Exams - witnessed from a taped video demonstration, reviewed on workstation)

_____ # Category A-2 (Contrast CCT Exams - witnessed from a taped video demonstration, not reviewed on workstation)

_____ # Category B (Contrast CCT Exams – not physically present/non-direct performance)

I verify that the applicant has interpreted witnessed, or interactively manipulated the above number and type of cases:

Signature: _____ Title: _____
Department Head, Imaging Facility Head, Medical Director or Hospital CEO

Printed Name: _____ Date: _____

E-Mail address _____ Phone: _____

Facility Name: _____ Address: _____

Institution #2:_____

Cases personally interpreted, witnessed, or interactively manipulated by applicant:

_____ # Category A (Contrast CCT Exams – physically present/direct performance)

_____ # Category A-1 (Contrast CCT Exams - witnessed from a taped video demonstration, reviewed on workstation)

_____ # Category A-2 (Contrast CCT Exams - witnessed from a taped video demonstration, not reviewed on workstation)

_____ # Category B (Contrast CCT Exams – not physically present/non-direct performance)

I verify that the applicant has interpreted witnessed, or interactively manipulated the above number and type of cases:

Signature: _____ Title: _____
Department Head, Imaging Facility Head, Medical Director or Hospital CEO

Printed Name: _____ Date: _____

E-Mail address _____ Phone: _____

Facility Name: _____ Address: _____

Institution #3:_____

Cases personally interpreted, witnessed, or interactively manipulated by applicant:

_____ # Category A (Contrast CCT Exams – physically present/direct performance)

_____ # Category A-1 (Contrast CCT Exams - witnessed from a taped video demonstration, reviewed on workstation)

_____ # Category A-2 (Contrast CCT Exams - witnessed from a taped video demonstration, not reviewed on workstation)

_____ # Category B (Contrast CCT Exams – not physically present/non-direct performance)

I verify that the applicant has interpreted witnessed, or interactively manipulated the above number and type of cases:

Signature: _____ Title: _____
Department Head, Imaging Facility Head, Medical Director or Hospital CEO

Printed Name: _____ Date: _____

E-Mail address _____ Phone: _____

Facility Name: _____ Address: _____

THIS SECTION MUST BE FILLED OUT AND COMPLETED IN ITS ENTIRETY BY THE APPLICANT

SUMMARY OF TOTAL CASES:

_____ # Category A (Contrast CCT Exams – physically present/direct performance)

_____ # Category A-1 (Contrast CCT Exams - witnessed from a taped video demonstration, reviewed on workstation)

_____ # Category A-2 (Contrast CCT Exams - witnessed from a taped video demonstration, not reviewed on workstation)

_____ # Category B (Contrast CCT Exams – not physically present/non-direct performance)

Total cases performed: _____

I, the undersigned applicant, attest that the foregoing represents the volume of cases personally interpreted, witnessed, or interactively manipulated by me within the prior 36 months.

Subscribed to and Sworn before me this

_____ day of _____, 20____

Signature of Applicant:_____

Date:_____

_____
Notary Public Signature

_____
Notary Public Printed Name

SEAL

Agreement to terms:

I, the undersigned applicant, recognize the Society of Cardiovascular Computed Tomography as the sole and only judge of my qualifications to receive and to retain Verification of Cardiovascular CT Experience, and further agree to hold harmless individually and collectively the Society of Cardiovascular Computed Tomography for any decision or action in pursuance of their duties in connection with this application, or for the failure of said Society to issue me a certificate of Verification of Cardiovascular CT Experience. I understand and agree that in the consideration of my application my moral, ethical and professional standing will be reviewed and assessed by the Society; that the Society may make inquiry of the persons named in my application and of such other persons as the Society deems appropriate with respect to my moral, ethical and professional standing; that if information is received which could adversely affect my application, I will be so advised and given an opportunity to rebut such allegations, but I will not be advised as to the identity of the individuals who have furnished adverse information concerning me; and that all statements and other information furnished to the Society in connection with such inquiry shall be confidential, and not subject to examination by me or by anyone acting on my behalf. I also pledge myself to the highest ethical standards in the practice of Cardiovascular Computed Tomography.

Signature of Applicant: _____ Date: _____

INSTRUCTIONS TO APPLICANT

1. Complete the application and enclose documentation as appropriate. All required signatures must be present for the application to be considered complete. Incomplete applications will be returned to the applicant.

2. Enclose fee of $250 for SCCT Members or $450 for Nonmembers (U.S. currency). Please make check payable to the **Society of Cardiovascular Computed Tomography**.

3. Return completed application, additional documentation, copies of CME certificates, anonymous case logs, and payment to:

Society of Cardiovascular Computed Tomography
Verification of Cardiovascular CT Experience Program
415 Church Street NE, suite 204.
Vienna, VA 22180
verification@scct.org
703-766-1712