

Individualized Program Application

1899 McKee Street, Ste. 126
San Diego, CA 92110

Phone: 619-543-6770

Fax: 619-543-2353

Email: ucpace@ucsd.edu

Web: paceprogram.ucsd.edu

INDIVIDUALIZED PROGRAM INFORMATION

Name and/or description of customized program of interest: _____

Has a proposal been created by PACE for this program? YES NO - If yes, please provide the name and contact information for the point of contact at your organization who has been working with PACE below:

NAME: _____

Phone: _____ Email: _____

CONTACT INFORMATION

NAME: _____

Last

First

Middle Initial

Gender: Male Female Date of Birth: _____

HOME ADDRESS (Please do not use P.O. boxes or P.O. ZIP codes as destination of correspondence):

Address _____

City _____ State _____ Zip Code _____

WORK ADDRESS (Please do not use P.O. boxes or P.O. ZIP codes as destination of correspondence):

Company Name (if applicable) _____

Address _____

City _____ State _____ Zip Code _____

Correspondence should be sent to: Home Address Work Address Other _____

Please check the corresponding box for the **best way** to reach you and preferred fax number:

Home Phone: _____ Work Fax: _____

Work Phone: _____ Home Fax: _____

Cell Phone: _____ Pager: _____

E-mail: _____

PRACTICE INFORMATION

Degree (please check one): M.D. D.O. D.P.M. P.A. Other: _____

Board certified in: _____ Date of last Recertification: _____

Board eligible in: _____

Specialty of current clinical practice: _____

State License Number: _____ DEA Number: _____

Has your license to practice medicine ever been suspended in any state? Yes No - If Yes, please give a brief explanation:

Are you currently practicing medicine? Yes No - If No, please state why:

Have you ever been denied or lost hospital privileges? Yes No - If Yes, please give a brief explanation.

Have you been denied, lost, had suspended or received any disciplinary action or is there any pending action regarding any license or privilege, including DEA license? Yes No - If yes, please give a brief explanation.

Do you have a Probation Investigator or Enforcement Monitor? Yes No - If yes, please provide their name and contact information.

Who referred you to the PACE Program (please select one)?

- Medical Board of California Other State Medical Board (identify): _____
- Private Hospital (name of hospital): _____
- Attorney: _____
- Self (how did you hear about us?): _____
- Other: _____

If you have been referred by a Hospital, are you coming as a requirement of the Medical Staff or Medical Executive Committee? Yes No

If you selected "yes" to the previous question, please provide their name and contact information in the space provided below:

CONSENT AND RELEASE OF INFORMATION

I authorize the University of California and the Physician Assessment and Clinical Education Program to disclose and exchange information pertaining to my participation in the Physician Assessment and Clinical Education Program and any of its offerings with **(please write in the name of the person(s) or entities to whom we can release your information** - e.g. State Medical Boards, Hospital Executive Committees, Attorneys, etc.):

Organization/Entity: _____

Person: _____

Address: _____

Phone and/or Email Address: _____

Organization/Entity: _____

Person: _____

Address: _____

Phone and/or Email Address: _____

Organization/Entity: _____

Person: _____

Address: _____

Phone and/or Email Address: _____

Organization/Entity: _____

Person: _____

Address: _____

Phone and/or Email Address: _____

I understand that information about my participation in the PACE program shall be available for inspection and review by above agencies and/or persons or by their designee at any time, and agree that it shall not be privileged in any way to the above agencies and/or designees.

By my signature below, I agree to hold harmless the Regents of the University of California, its officers, agents and employees from any liability resulting from or arising in connection with this agreement.

Signature

Print Name

Date

PAYMENT & PROCESSING INFORMATION

THIS IS A PRELIMINARY APPLICATION
ONCE YOUR APPLICATION IS RECEIVED, WE WILL SEND YOU A LETTER
WITH FURTHER INSTRUCTIONS

SHIPPING AND MAILING ADDRESS:

UCSD PACE Program
1899 McKee Street, #126
San Diego, CA 92110

FOR MORE INFORMATION OR TO CONTACT US:

Phone: (619) 543-6770
Fax: (619) 543-2353
E-mail: ucpace@ucsd.edu
Internet: paceprogram.ucsd.edu

SELECT THE APPLICABLE PAYMENT:

1st OPTION:

Pay Application Fee* Only: \$500

2nd OPTION:

Pay Full Balance: \$_____

A \$500 Application Fee is required for PACE to commence a needs assessment, secure instructor(s), and prepare a proposal for individualized programs. The \$500 fee will be applied to the balance of the cost of the individualized program. If for some reason, PACE is unable to secure instructors or continue the needs assessment process, the fee is refundable in full.

CANCELLATION POLICY

- There is a 50% administrative fee for cancellation more than two weeks before the course. Refund of the remaining balance is possible.
- There is a 90% administrative fee for cancellation two weeks or less before the course. Refund of the remaining balance is possible.
- There is a 100% administrative fee for "no show."

CHECK INFORMATION:

Make all checks or money orders payable to "UC Regents."

CREDIT CARD INFORMATION:

I authorize the UCSD PACE Program to charge my credit card for the amount noted below.

Total Amount to be charged: \$_____ Last Four Digits of CC: _____

Authorization Signature: _____ Date: _____

STOP! We request that you NOT send credit card information electronically (via fax or email). Please complete the form below if you are sending the application by mail. **Otherwise, please complete and send the above section only, and then contact our office at 619-543-6770 to provide the payment information.**

- Master
 Visa
 American Express
 Discover
 Diners Club

Card Holder's Name: _____

Card Number: _____

Exp. Date (mm/yy): _____ Card Security Number: _____

Credit Card Billing Address: _____

Credit Card Billing Zip Code: _____