UC San Diego
SCHOOL OF MEDICINE

Physician Assessment and Clinical Education (PACE) Program

CME Course Application

New Mailing Address as of 2019:
200 West Arbor Drive, #8204
San Diego, CA 92103

Phone: 619-543-6770, Email: ucpace@ucsd.edu
General Fax: 619-488-6078
Web: paceprogram.ucsd.edu

Note: As of March, 18 2020 and until further notice, PACE CME Courses are offered in an online format at a reduced rate.

AVAILABLE PROGRAMS (please select all programs for which you are applying):

☐ Physician Prescribing Course ***(CURRENTLY ONLINE)***	$1,495 → Requested Dates: _____
☐ Medical Record Keeping Course ***(CURRENTLY ONLINE)***	$1,150 → Requested Dates: _____
☐ Clinician-Patient Communication Course ***(CURRENTLY ONLINE)***	$750 → Requested Dates: _____
☐ Professional Boundaries Program ***(CURRENTLY ONLINE)***	$2,625 → Requested Dates: _____
☐ Anger Management Course ***(CURRENTLY ONLINE)***	$2,625 → Requested Dates: _____

For customized/individualized programs, please use the "PACE Individualized Program Registration Form".

NAME: _____
Last First Middle Initial

ADDRESS: _____

_____

Phone: ☐ Work / ☐ Home _____ Cell: _____

Fax: _____ E-mail: _____

Gender: ☐ Male ☐ Female Date of Birth: _____

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: _____

Are you currently practicing medicine? ☐ Yes ☐ No

REFERRAL INFORMATION

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

☐ State Medical Board (Write in Name of Board): _____

☐ Private Hospital/Medical Group (Org Name): _____

Point of Contact/Cmte.: _____

☐ Attorney: _____

☐ Self (how did you hear about us?): _____

☐ Other: _____

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:_____

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 deemed privileged or confidential in any way to the above agencies and/or designees by virtue of this express authorization.

☐ In the event I do not elect to authorize release of records or information pertaining to my participation in the PACE Program to any individuals or entities.

I understand and acknowledge that this release does not alter or limit the ability of the University of California and the PACE Program to comply with law, regulation, or court order which may require disclosure of records and/or information related to my participation in the PACE Program.

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

MAILING ADDRESS: UC San Diego PACE Program
200 West Arbor Drive, #8204
San Diego, CA 92103

SHIPPING ADDRESS: 1550 Hotel Circle North,
Suite 320
San Diego, CA 92108

FOR MORE INFORMATION OR TO CONTACT US:

Phone: (619) 543-6770
Fax: (619) 488-6078
E-mail: ucpace@ucsd.edu
Internet: paceprogram.ucsd.edu

MULTI-COURSE DISCOUNT:
Participants applying for multiple PACE courses are eligible for a discount at the time of enrollment. Courses must be applied for at the same time to receive the discount. Additional custom modules added to courses are *not* applicable.
Two courses = 10% off
Three or more courses = 15% off

CANCELLATION POLICY

- There is a $100 administrative fee for cancellation more than two weeks before the course, refund of the remaining balance is possible.
- There is a $250 administrative fee for cancellation two weeks or less before the course, refund of the remaining balance is possible.
- There is a $250 administrative fee for "no show." No refund is possible. However, the remaining balance can be applied to a future course.

☐ Prescribing	$1,495
☐ Medical Record Keeping	$1,150
☐ Communication	$750
☐ Boundaries	$2,625
☐ Anger Management	$2,625
☐ Custom Course	_____

(use "Individualized Course" application)

Course Subtotal _____

Multi-Course Discount (if applicable) _____

Course Total _____

CHECK INFORMATION

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

CREDIT CARD INFORMATION

IF PROVIDING CREDIT INFORMATION:
Step 1: **Just authorize** the payment below.
Step 2: Submit your application to PACE.
Step 2: Call the front desk at 619-543-6770 with the full payment info and it will be purged upon processing.

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: _____ Today's Date: _____

PLEASE DO NOT INCLUDE YOUR CREDIT CARD DATA ON THIS FORM. AUTHORIZATIONS THAT INCLUDE CREDIT CARD DATA WILL NOT BE PROCESSED AND THE FORM WILL BE DESTROYED OR DELETED AND WILL NEED TO BE RESENT.