

# CME Course Application

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

Phone: 619-543-6770

Fax: 619-543-2353

Email: [ucpace@ucsd.edu](mailto:ucpace@ucsd.edu)

Web: [paceprogram.ucsd.edu](http://paceprogram.ucsd.edu)

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

- |  |         |                                  |
|--|---------|----------------------------------|
| <input type="checkbox"/> Physician Prescribing Course            | \$1,995 | → Requested Dates: _____         |
| <input type="checkbox"/> Medical Record Keeping Course           | \$1,575 | → Requested Dates: _____         |
| <input type="checkbox"/> Clinician-Patient Communication Course  | \$1,000 | → Requested Dates: _____         |
| <input type="checkbox"/> Professional Boundaries Program         | \$3,500 | → Requested Dates: _____         |
| <input type="checkbox"/> Anger Management Course                 | \$3,500 | → Requested Dates: _____         |
| <input type="checkbox"/> Anger Mgmt. Intensive Follow-Up Program | \$3,900 | → Will be scheduled individually |

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 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](mailto:ucpace@ucsd.edu)  
Internet: [paceprogram.ucsd.edu](http://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 (including the Anger Management Follow-Up Program) are not applicable.

Two courses = 10% off

Three or more courses = 15% off

\*The Supervising Mid-Level Practitioners course has a discounted rate of \$650 for mid-level practitioners.

### 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.

<input type="checkbox"/> Prescribing	\$1,995
<input type="checkbox"/> Medical Record Keeping	\$1,575
<input type="checkbox"/> Communication	\$1,000
<input type="checkbox"/> Boundaries	\$3,500
<input type="checkbox"/> Anger Management	\$3,500
<input type="checkbox"/> Anger Mgmt. Follow-Up	\$3,900
<input type="checkbox"/> 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 FAXING OR EMAILING YOUR APPLICATION

Step 1: **Just authorize** the payment by filling out **SECTION A**.

Step 2: Call the front desk at 619-543-6770 with the full payment info and it will be purged upon processing.

IF MAILING YOUR APPLICATION, please complete both sections.

<b>SECTION A.</b>	<b>I authorize the UCSD PACE Program to charge my credit card for the amount noted below.</b>	
	Total Amount to be charged: \$ _____ Last Four Digits of CC: _____	
Authorization Signature: _____		Date: _____
<b>SECTION B.</b>	<input type="checkbox"/> Master	Card Holder's Name: _____
	<input type="checkbox"/> Visa	Card Number: _____
	<input type="checkbox"/> American Express	Exp. Date (mm/yy): _____ Card Security Number: _____
	<input type="checkbox"/> Discover	Credit Card Billing Address: _____
	<input type="checkbox"/> Diners Club	Credit Card Billing Zip Code: _____