UC San Diego
PACE PROGRAM

Physician Assessment and Clinical Education (PACE) Program

Competence Assessment / PEP 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

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

☐ Competency Assessment and Clinical Education
☐ Professional Enhancement Program (PEP)

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: _____

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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, we will need to contact the chair of the referring committee. Please provide their name and contact information in the space provided below:

_____

_____

_____

What are the circumstances that led up to your referral or application to the PACE Program? (If more space is needed, please write on the back of this page or on a separate piece of paper)

_____

_____

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.):

_____

_____

_____

_____

_____

_____

_____

_____

I understand that one or more of the standard testing modalities that I will participate in will be videotaped for documentation as part of the routine assessment protocol. These tapes may be used for training purposes and to enhance consistency in scoring and standardization in testing. There will be no disclosure of the video images outside of the treatment team and training program, except as required by law. I understand that I may be required to undergo a toxicology screening/substance abuse evaluation as part of my assessment.

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

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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

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

SELECT THE APPLICABLE PAYMENT(S)

PACE Competence Assessment Program

1ST OPTION:

☐ Pay Application Fee Only $350

2nd OPTION:

☐ Deposit Towards Balance $10,500

☐ **EXPEDITED SCHEDULING FEE*** $1,000

PACE Physician Enhancement Program (PEP)

☐ Application Fee $350

TOTAL = _____

*Application fee is included in Phase I balance. See Price List for more details.

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: _____