



**UNIVERSITY OF CALIFORNIA, SAN DIEGO, SCHOOL OF MEDICINE
PHYSICIAN ASSESSMENT AND CLINICAL EDUCATION PROGRAM**

APPLICATION

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

- Assessment and Clinical Education
- Professional Enhancement Program (PEP)

Please include a non-refundable \$350 processing fee with this Application. Make checks payable to "UC Regents." For credit card payments, please use the space provided at the end of this form.

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 indicate the best way to reach you and preferred fax number:

- Home Phone: _____ Work Fax: _____
- Work Phone: _____ Home Fax: _____
- Cell Phone: _____ E-mail: _____
- Pager: _____

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 (please 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)

University of California, San Diego
School of Medicine
PHYSICIAN ASSESSMENT AND CLINICAL EDUCATION PROGRAM (PACE)

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 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 INFORMATION

CHECK INFORMATION

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

CREDIT CARD INFORMATION

Master Card Holder's Name: _____
 Visa Card Number: _____
 American Express Exp. Date (mm/yy): _____
 Discover Card Security Number: _____
 Diners Club

Total Amount to be charged: \$ _____

Authorization Signature: _____ Date: _____

**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:

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