



**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
- Custom 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: _____ Social Security Number _____

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: _____

What is the nature of your clinical practice (please check all that apply)?

- Office Based
 - Solo Private Practice
 - Group
 - HMO
- Hospital Based
- Locum Tenens
- Nursing Home
- Correctional Medicine
- Academic
- Military
- Other: _____

For your most recent week of typical practice, how many hours did you spend:

- a. Seeing patients in an office or clinic? _____ hrs/week
- b. Seeing patients in hospital/not emergency room? _____ hrs/week
- c. Seeing patients in an emergency or urgent care facility? _____ hrs/week
- d. Seeing patients in nursing homes, other extended care facility? _____ hrs/week
- e. Seeing patients in home visits? _____ hrs/week
- f. Performing Surgery? _____ hrs/week
- g. Administration? _____ hrs/week
- h. Teaching? _____ hrs/week
- i. Other? _____ hrs/week

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
- Arizona Medical Board
- Other State Medical Board (please identify): _____
- Attorney
- Private Hospital (name of hospital): _____
- Self
- 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:

CHECK AND CREDIT CARD INFORMATION

CHECK INFORMATION

Make all checks payable to "UC Regents."

CREDIT CARD INFORMATION

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

Total Amount to be charged: \$ _____

Authorization Signature: _____ Date: _____

**THIS IS A PRELIMINARY APPLICATION.
ONCE YOUR APPLICATION IS RECEIVED, YOU WILL BE SENT A LETTER EITHER CONFIRMING YOUR
ENROLLMENT OR REQUESTING ADDITIONAL INFORMATION.**

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
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 (e.g. Medical Board of California, other 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