UC San Diego
School of Medicine

# PACE Program

Physician Assessment and Clinical Education Program

**Mailing Address:**
1550 Hotel Circle N, Ste 320, San Diego, CA 92108
**Email:** ucpace@ucsd.edu
**Phone:** 619.543.6770
**Fax:** 619.488.6078
**Paceprogram.ucsd.edu**

## Late Career Health Screening Application

### CONTACT INFORMATION

NAME_____
Last First Middle Initial

GENDER ☐ Male ☐ Female ☐ Self-Identify:_____DATE OF BIRTH_____

EMAIL_____ CELL PHONE_____

* By providing an email address, you agree to have all correspondence from pace sent via email. If you would like hard copies sent to another address, please indicate where they should be sent below:

SEND HARD COPIES TO: ☐ Home Address ☐ Work Address ☐ Other_____

WORK PHONE_____ HOME PHONE _____ FAX_____

HOME ADDRESS_____

WORK NAME (IF APPLICABLE) _____

WORK ADDRESS_____

### PRACTICE INFORMATION

Degree (check one) ☐ M.D. ☐ D.O. ☐ D.P.M. ☐ P.A. ☐ Other_____

Specialty of current clinical practice:_____

State License Number_____ Are you currently practicing medicine? ☐ Yes ☐ No*

*Why did you stop practicing?_____

*Date of most recent practice (month/year):_____/_____

Do you perform suturing in your practice? ☐ Yes ☐ No

Do you perform any procedures in your practice? ☐ Yes ☐ No

## REFERRAL INFORMATION

**Which of the following statements best describes why you are applying for the Late Career Health Screening?**

A. ☐ My hospital or medical group enacted a policy requiring physicians and/or other healthcare professionals of a certain age to undergo an independent health evaluation.

B. ☐ My State Medical Board or Physician Health Program has asked me to obtain an independent health evaluation.

C. ☐ I am concerned that my health could be affecting my ability to practice safely.

D. ☐ Others have raised concerns about my health possibly affecting my ability to practice.

E. ☐ Other:_____

**If you selected "Hospital/Medical Group," please provide the following information about the hospital or medical group:**

Legal Name of Entity_____

Name/Title of Contact Person_____

Phone Number: _____ Email: _____

If you selected any other referral source, please call the PACE office at (619) 543-6770 before submitting this application to make sure that the Late Career Health Screening is right for you.

**CONSENT, AUTHORIZATION TO RELEASE OF INFORMATION, AND HOLD HARMLESS**

☐ I authorize the University of California and the Physician Assessment and Clinical Education Program (the "Program") to disclose and exchange information pertaining to my participation in the 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.):

_____

_____

_____

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_____

I understand that information about my participation in the Program shall be available for inspection and review by the above agencies and/or persons or by their designee at any time. By virtue of this express authorization, I voluntarily waive any privilege or privacy right which may attach to such information released to the above agencies and/or designees.

I understand that I may be required to undergo a toxicology screening/substance abuse evaluation as part of my assessment. As a condition of my participation in the Program, I consent to such screening and evaluation procedures.

I acknowledge and agree not to electronically record any sessions that I participate in as a result of the PACE assessment. PACE, and all of its agents, do not agree to be electronically recorded. I acknowledge that if I electronically record a PACE session, PACE will pursue all available remedies to prohibit my use and/or dissemination of the unlawfully obtained recording.

☐ I do not elect to authorize release of records or information pertaining to my participation in the PACE Program to any individuals or entities, except as required by law.

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 indemnify and 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 for my participation in the Program and any release of records associated therewith.

_____
Signature

_____
Print Name

_____
Date

## PAYMENT AND APPLICATION PROCESSING

**PLEASE NOTE:** THIS IS ONLY A PRELIMINARY APPLICATION. UPON RECEIPT OF YOUR APPLICATION, WE WILL SEND AN EMAIL WITH FURTHER INSTRUCTIONS FOR ENROLLMENT.

**COSTS- LATE CAREER HEALTH SCREENINGS**

| | |
|---|---|
| Non-Proceduralists | $2,000 |
| Proceduralists* | $2,200 |

*Only select if you suture in your practice

**TO PAY BY CREDIT CARD *(fastest/preferred method)***
Please email or fax the completed application to:
Email: ucpace@ucsd.edu
Fax: 619.488.6078

After your *completed** application is received, you will receive an email with an invoice and instructions to complete an online credit card payment. Once your payment is received, we will send you an email confirming receipt of your application and further enrollment information.

*Make sure you've included this required information on your application: Your name, phone number, email address, and signed "Consent and Release of Information" form.
Most applicants receive an invoice within 1 business day of submitting their application via email or fax.

**TO PAY BY CHECK OR MONEY ORDER**
Please mail your completed application *with* check or money order for class total made payable to "UC REGENTS" to:

**PRIMARY Mailing Address**
***(Must use for FedEx, UPS, USPS Priority):***
1550 Hotel Circle N, Ste 320
San Diego, CA 92108*
*Also physical address of PACE offices

**UC San Diego Campus Mailing Address:**
200 West Arbor Drive,
Mail Code 8204
San Diego, CA 92103

**ENSURE YOUR ENROLLMENT**
In order to register for a screening, we require your completed application along with full payment of screening costs.

**CANCELLATION, REFUND AND TRANSFER POLICY ON NEXT PAGE.**

**CANCELLATION, REFUND AND TRANSFER POLICY FOR LATE CAREER HEALTH SCREENINGS**

- LCHS's that have not commenced are eligible for a refund as follows
  - Cancellation requests received prior to scheduling are eligible for a refund, less a 10% processing fee.
  - Cancellation requests received seven (7) days or more from the commencement of the LCHS are eligible for a refund of 50% of all fees paid.
  - Cancellation requests received six (6) days or fewer from the commencement of the LCHS are not eligible for refund.
- Requests to reschedule a LCHS received seven (7) days or more from its commencement will result in a rescheduling fee of $250.
- Requests to reschedule a LCHS received six (6) days or fewer from its commencement will result in a rescheduling fee of $500.
- Once a LCHS is rescheduled, it will no longer be eligible for refund. Future requests to reschedule a LCHS after it has already been rescheduled will incur higher rescheduling costs as outlined below:
  - Requests to reschedule a LCHS received seven (7) days or more from its commencement will result in a rescheduling fee of $500.
  - Requests to reschedule a LCHS received six (6) days or fewer from its commencement will result in a rescheduling fee of $1000.

All notifications of cancellation, or requests to reschedule a LCHS must be made in writing via email (ucpace@ucsd.edu) or fax (619-488-6078) to the attention of the Administrative Director of the Late Career Health Screening Program. Refunds are issued in the method the payment was made. Credit/debit card refunds will be credited back to the card originally charged, and a check from UCSD will be issued if you paid by check.

If you have questions about the application process, please call (619) 543-6770 or email ucpace@ucsd.edu.