UC San Diego
SCHOOL OF MEDICINE

Physician Assessment and Clinical Education (PACE) Program

Fitness for Duty Evaluation Application

New Mailing Address as of 2019:
200 West Arbor Drive, #8204
San Diego, CA 92103

Phone: 619-543-6770, Email: ucpace@ucsd.edu
General Fax: 619-488-6078, PEP Program Fax: 619-488-6105
Web: paceprogram.ucsd.edu

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: ____________________

UC San Diego SCHOOL OF MEDICINE PACE Program

Fitness for Duty Evaluation Application

1. Are you currently practicing medicine? ☐ Yes ☐ No
   (If yes, please move on to the next question. If no, please answer the following):
   a. What is the month and year you most recently practiced: ________/____________
   b. What is the current status of your medical license:
      ☐ Active
      ☐ Suspended (if applicable, list date (mo/yr) the suspension will be lifted):_______/____________
      ☐ Revoked
      ☐ Expired (date of expiration): _____/____________

2. Are you currently on probation? ☐ Yes or ☐ No (If Yes, how long is your probation (months):__________

3. Do you have any restrictions on your license?: ☐ Yes ☐ No – If Yes, please list restrictions on your license:

   ____

   ____

   ____

4. Have you ever been denied or lost hospital privileges? ☐ Yes ☐ No - If Yes, please give a brief explanation.

   ____

   ____

   ____

5. 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.

   ____

   ____

   ____

6. 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)

   ____

   ____

   ____

7. Who referred you to the PACE Program?:

   ☐ Hospital/Medical Group (Please list legal name):______________________________

   ☐ State Medical Board (Please list):______________________________

   ☐ Attorney (Please list name of firm):______________________________

   ☐ Other (Please list name): ______________________________

8. Please provide the following for the referring institution's point of contact:

Name: ______________________________ Phone Number: ______________________

Email: ____

9. Do you have a history of substance abuse? ☐ Yes ☐ No

   If yes, what type of substance abuse? ____

   ____

   ____

10. Are you currently enrolled in a treatment/monitoring program? ☐ Yes ☐ No

    If yes, please provide the following information:

    Treatment program ____

    Address ____

    Counselor or monitor name ______________________Email ______________________

    Up to today, how long have you been drug/alcohol-free? ______________________________

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.):

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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. I understand that I may be required to undergo a toxicology screening/substance abuse evaluation as part of my assessment.

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

MAILING ADDRESS: UC San Diego PACE Program
200 West Arbor Drive, #8204
San Diego, CA 92103

SHIPPING ADDRESS: 1550 Hotel Circle North,
Suite 320
San Diego, CA 92108

FOR MORE INFORMATION OR TO CONTACT US:

Phone: (619) 543-6770
Fax: (619) 488-6078
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 Fitness for Duty Evaluation

1ST OPTION:

☐ Pay Application Fee Only (non-refundable) $550

2nd OPTION:

☐ Pay Fitness for Duty Deposit* (required for complete enrollment) $8000

* Fitness for Duty deposit includes application fee.

PLEASE NOTE: Deposit is not the total cost of the program. Once the components of your evaluation have been determined, you will receive a program outline with a remaining balance.

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.

SECTION A.

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: ______________

SECTION B.

☐ 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: ______________