UC San Diego
SCHOOL OF MEDICINE

Physician Assessment and Clinical Education (PACE) Program

Individualized Program 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

INDIVIDUALIZED PROGRAM INFORMATION

Name and/or description of customized program of interest: _____

_____

Has a proposal been created by PACE for this program? ☐ YES ☐ NO - If yes, please provide the name and contact information for the point of contact at your organization who has been working with PACE below:

NAME: _____

Phone: _____ Email: _____

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: _____

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, please provide their name and contact information in the space provided below:

_____

_____

_____

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.):

Organization/Entity: _____

Person: _____

Address: _____

Phone and/or Email Address: _____

Organization/Entity: _____

Person: _____

Address: _____

Phone and/or Email Address: _____

Organization/Entity: _____

Person: _____

Address: _____

Phone and/or Email Address: _____

Organization/Entity: _____

Person: _____

Address: _____

Phone and/or Email Address: _____

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 & 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

SELECT THE APPLICABLE PAYMENT:

1st OPTION:
☐ Pay Application Fee* Only: $ 500
2nd OPTION:
☐ Pay Full Balance: $ _____

*A $500 Application Fee is required for PACE to commence a needs assessment, secure instructor(s), and prepare a proposal for individualized programs. The $500 fee will be applied to the balance of the cost of the individualized program. If for some reason, PACE is unable to secure instructors or continue the needs assessment process, the fee is refundable in full.

CANCELLATION POLICY

- There is a 50% administrative fee for cancellation more than two weeks before the course. Refund of the remaining balance is possible.
- There is a 90% administrative fee for cancellation two weeks or less before the course. Refund of the remaining balance is possible.
- There is a 100% administrative fee for "no show."

CHECK INFORMATION

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

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: _____