UC San Diego
SCHOOL OF MEDICINE

Physician Assessment and Clinical Education (PACE) Program

Competency Assessment / PEP 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

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

☐ Competency Assessment and Clinical Education
☐ Professional Enhancement Program (PEP)

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:

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Are you currently practicing medicine? ☐ Yes ☐ No – If No, please state why:

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

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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.

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___

Do you have a Probation Investigator or Enforcement Monitor? ☐ Yes ☐ No – If yes, please provide their name and contact information.

___

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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, 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)

___

___

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

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

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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(S)

PACE Competency Assessment Program

1ST OPTION:

☐ Pay Application Fee Only $350

2nd OPTION:

☐ Deposit Towards Balance $10,500

PACE Physician Enhancement Program (PEP)

☐ Application Fee $350

TOTAL = ___________

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: ____________________