UC San Diego
PACE PROGRAM

Physician Assessment and Clinical Education (PACE) Program

Fitness for Duty Evaluation Application

1899 McKee Street, Ste. 126
San Diego, CA 92110

Phone: 619-543-6770
Fax: 619-543-2353
Email: ucpace@ucsd.edu
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: ____________________

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FFD 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.):

____
____
____
____
____
____
____
____
____

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

UC San Diego PACE PROGRAM

FFD Evaluation Application

PAYMENT & PROCESSING INFORMATION

THIS IS A PRELIMINARY APPLICATION
ONCE YOUR APPLICATION IS RECEIVED, WE WILL SEND YOU A LETTER
WITH FURTHER INSTRUCTIONS

SHIPPING AND MAILING ADDRESS:

UCSD PACE Program
1899 McKee Street, #126
San Diego, CA 92110

FOR MORE INFORMATION OR TO CONTACT US:

Phone: (619) 543-6770
Fax: (619) 543-2353
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: ________