



Acceptance of Appointment by _____, M.D.

I hereby acknowledge and accept appointment to the **DEPARTMENT OF OPHTHALMOLOGY**
as a **Resident Physician 2** at UC San Diego Shiley Eye Center for the period **June 30, 2009**
through **June 30, 2010**.

New Appointee Only: I wish uniforms to be ordered: Yes No

Lab Coat Size: _____

California Medical License Number: _____ Expiration Date: _____

Authorized to prescribe the following schedules of controlled drugs: 2 2N 3 3N 4 5

Copy of your current wallet size California Medical License certificate attached

Copy of DEA certificate attached

Signed _____

Date _____

Photocopy if you wish to retain a copy for your records and forward the original SIGNED form to:

**Graduate Medical Education, Mail Code 8829
UCSD Medical Center
200 West Arbor Drive
San Diego, California 92103-8829**