UC DAVIS
SCHOOL OF MEDICINE
HEALTH SCIENCES COMPENSATION PLAN STATEMENT

In association with the terms of my appointment, I have received and read copies of the *University of California Health Sciences Compensation Plan,* the *Health Sciences Compensation Plan Implementation Procedures for the UC Davis School of Medicine, and compensation plan procedures for my home department*. I agree to comply with all of the conditions outlined therein and in any successor Plans. I will not retain any professional income except as provided.

_____

PRINT NAME **DATE**

_____

SIGNATURE **DATE**

Attachments

University of California Health Sciences Compensation Plan (11/23/99)
Health Sciences Compensation Plan Implementation Procedures for the UC Davis School of Medicine (revised 7/1/05).

*Please return this form to your department for inclusion with your employment forms. Employment forms will **not** be processed without this Compensation Plan Statement.*