

**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.

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**PRINT NAME**

**DATE**

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**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.*