**HEALTH SCIENCES COMPENSATION PLAN**

# STATEMENT OF AGREEMENT

I certify that I have received a copy of the University of California Health Sciences Compensation Plan and the UCI School of Medicine Implementation Procedures. I agree to comply withall of the terms and conditions contained therein. I understand that I may not retain any income from my professional services except as stipulated in those documents. I understand that 100% of my professional commitment is to the University. I understand further that compliance with provisions contained in The Health Sciences Compensation Plan and these Implementation Procedures is a condition of employment for Plan members.

Faculty Name:

Department:

**PLAN PARTICIPANT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_**

 ***Signature***