# ECFMG® | Payment for Service(s) Requested Form 900

PAYMENT

**BY MAIL:** ECFMG, PO Box 13679, Philadelphia, PA 19101-3679 USA
**BY COURIER:** ECFMG, 3624 Market Street, Philadelphia, PA 19104-2685 USA
**TELEPHONE:** (215) 386-5900 • **FAX:** (215) 386-3185 • **INTERNET:** www.ecfmg.org

## 1

Enter your Identification Number.

Enter your name.

**USMLE® / ECFMG® Identification Number:** ☐ – ☐☐☐ – ☐☐☐ – ☐

**First Name(s)**

**Middle Name(s)**

**Last Name(s) (Surname or Family Name)**

**Generational Suffix (Jr, Sr, II, III, IV)**

## 2

Indicate the service(s) for which you are providing payment.

- ☐ Extension of USMLE Step 1 / Step 2 CK Eligibility Period ($65 per exam)
- ☐ ERAS® Token ($90) – ERAS Applicants: Do NOT use this form to pay for transmission of your USMLE transcript via ERAS. Instead, login to www.myeras.aamc.org.
- ☐ USMLE Transcript ($50 per request form – up to 10 transcripts) – ERAS Applicants: Do NOT use this form to pay for transmission of your USMLE transcript via ERAS. Instead, login to www.myeras.aamc.org.
- ☐ ECFMG Exam Chart ($50 per request form – up to three copies)
- ☐ ECFMG CSA History Chart ($50 per request form – up to 10 copies)
- ☐ CVS – State Board ($35)
- ☐ EVSP (J-1 VISA) ($275)
- ☐ Score Recheck: USMLE Step 1/Step 2 CK/Step 2 CS ($80 per exam)
- ☐ Duplicate ECFMG Certificate ($50)
- ☐ Name Change on ECFMG Certificate ($50)
- ☐ File Copy Fee ($25)
- ☐ Translation Fee – Medical School Transcript ($220)
- ☐ Application for ECFMG Certification ($50)

Previous Balance/Other (Specify):

- ☐ $ _____

## 3

Select a method of payment and complete all information requested.

Do **NOT** send cash.

**(A)** ☐ **Charge my credit card.**

**Credit Card Number:** ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ **Exp. Date (Month/Year):** ☐☐ / ☐☐☐☐

**Check One:** ☐ **VISA** ☐ **MASTERCARD** ☐ **DISCOVER** ☐ **AMERICAN EXPRESS**

**Name of Card Holder:** _____

**Address of Card Holder:** _____

**City:** _____

**State:** _____

**Country:** _____

**Zip/Postal Code:** _____

By signing below, I authorize ECFMG to charge my credit card in the amount indicated above.

**Signature of Card Holder:** _____

**(B)** ☐ **My check, bank draft, or money order made payable to ECFMG is enclosed.**
Payment must be made in U.S. funds through a U.S. bank. Include your USMLE/ECFMG Identification Number on your check.

For detailed information on ECFMG's Payment and Refund policies, refer to the ECFMG *Information Booklet* and to the ECFMG website at www.ecfmg.org.

**This form is available on the ECFMG website at www.ecfmg.org.**