1. Enter your Identification Number.

2. Enter your name.

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

   - Application for ECFMG Certification ($145)
   - Application for USMLE Step 1/Step 2 CK ($965 per exam*)
   - Application for USMLE Step 2 CS ($1,600 per exam)
   - Extension of USMLE Step 1/Step 2 CK Eligibility Period ($90 per exam)
   - Testing Region Change: USMLE Step 1/Step 2 CK Eligibility Period ($85 per region change*)
   - Score Recheck: USMLE Step 1/Step 2 CK ($85 per region change*)
   - ERAS® Token ($145) – ERAS Applicants: Do NOT use this form to pay for transmission of your USMLE Transcript via ERAS. Instead, log in to AAMC’s MyERAS website.
   - USMLE Transcript ($70 per request form – up to 10 transcripts) – This form is for institutional payments (accompanying Form 173) only. Individuals submitting Form 172 should see that form for payment instructions. ECFMG applicants paying for transmission of their USMLE Transcript should log in to AAMC’s MyERAS website.
   - 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 ($55)
   - EVSP (J-1 visa sponsorship) ($350)
   - Name Change on ECFMG Certificate ($50)
   - File Copy Fee ($25)
   - Translation Fee – Medical School Transcript ($250)

   *International test delivery surcharges also may apply and must be included in payment. For the list of fees, see the ECFMG website at www.ecfmg.org/fees.

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.