Payment for Service(s) Requested
Form 900

Do NOT submit this form to ECFMG by e-mail. Please submit the completed form using one of the following methods:
- BY MAIL/COURIER: ECFMG, 3624 Market Street, 4th Floor, Philadelphia, PA 19104-2685 USA, or
- FAX: (215) 386-3185

1

Enter your Identification Number.

Enter your name.

2

□ Application for ECFMG Certification ($150)
□ Application for USMLE Step 1/Step 2 CK ($975 per exam*)
□ Extension of USMLE Step 1/Step 2 CK Eligibility Period ($90 per exam)
□ Testing Region Change: USMLE Step 1/Step 2 CK ($85 per region change*)
□ Score Recheck: USMLE Step 1/Step 2 CK ($80 per exam)
□ 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. ERAS 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 ($60)
□ EVSP (J-1 visa sponsorship) ($360)
□ Reprint ECFMG Certificate ($50)
□ 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: [Redacted]

Check One: □ VISA □ MASTERCARD □ DISCOVER □ AMERICAN EXPRESS

Exp. Date (Month/Year): [Redacted]

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 website at www.ecfmg.org/fees/payment.html.

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