



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.

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.

- ☐ Application for ECFMG Certification (\$160)
- ☐ Application for USMLE Step 1/Step 2 CK (\$985 per exam\*)
- ☐ Extension of USMLE Step 1/Step 2 CK Eligibility Period (\$100 per exam)
- ☐ Testing Region Change: USMLE Step 1/Step 2 CK (\$90 per region change\*)
- ☐ Score Recheck: USMLE Step 1/Step 2 CK (\$80 per exam)
- ☐ ERAS® Token (\$155) – 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 (\$66)
- ☐ EVSP (J-1 visa sponsorship) (\$370)
- ☐ 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.ecfm.org/fees](http://www.ecfm.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.