New York Medical College

Credit Card Payment Form

Please check one of the following:

[ ] SCHOOL OF HEALTH SCIENCES & PRACTICE
[ ] GRADUATE SCHOOL OF BASIC MEDICAL SCIENCES

Type or print in ink. Complete all information on this form.

____ ______________________________
First and Last Name (Print) Student ID# or SS#

Type of Payment: [ ] Master Card
[ ] Visa

Credit Card Number: ____________ - ____________ - ___________ - ___________

Expiration Date: _____________

Amount to be charged: $_________________ Zip Code: ______________

By signing this form I'm authorizing New York Medical College to process my charge. If for any reason my credit card is declined, I understand that New York Medical College will not accept my graduation application and it will be returned to me.

Authorized signature: ____ Date: ______________