



Organization: _____

Student Name (s): _____

To Whom It May Concern:

The New York College of Podiatric Medicine has established processing fees for the activities listed below:

Verification of Education (must remit to verify) - \$10.00 / Per Applicant

Kindly remit a check or money order payable to **NYCPM** in the amount of \$10 (per provider) **along with your original request**, to cover the cost of your requested education verification.

Please mail a check or money order attention to the Registrar's Office to:

New York College of Podiatric Medicine
Attn: Registrar's Office
53 East 124th Street
New York, NY 10035

To pay by credit card **please contact the Bursar's Office at (212) 410-8039** or **enter your payment information below**. We appreciate your cooperation. You can return this form via e-mail to aroberts@nycpm.edu or fax it to (212) 722-4918.

Sincerely,

Andrew Roberts
Assistant Registrar

Payment Information:

American Express Card #: _____

Expiration Date: ___/___ - 4 digit code _____

MasterCard/Visa Card #: _____

Expiration Date: ___/___ - 3 digit code _____