SUNY Downstate Medical Center | Office of Continuing Medical Education

Request for CME Certificate/Transcript

Date of Request:	
Name:	
Degree (MD, PA, etc.):	
Facility/Dept.:	
Telephone:	
☐ **Transcript(s) ($20 per academic year)**	
Academic Year(s) Requested for:	
Title of grand rounds, Date of Occurrence, Presented by (Hospital/Department:	
☐ **Certificate(s) ($20 per conference)**	
Title of Conference, Date of Occurrence, Presented by (Hospital/Department):	

PAYMENT METHOD:

☐ **Check#** _____ **Other** ☐

Credit Card payment:(MC,VISA, & Discover only)

Credit cards users, please fax CC information

Amount authorized: _____

Card#: _____ **Exp. Date:**_____

***3 Digit Security Code:**_____

Name as it appear on card:_____

Signature & Date:_____

I hereby authorize SUNY Downstate to charge my credit card for the amount indicated above.

Delivery Method	☐ **Will Pick Up** ☐ **Fax#** _____ ☐ **Mailbox #** _____
Send to Address:	

Return this form to Box 1244 or fax to (718) 270-4563. The $20 processing fee can be paid at the Bursar office or you may forward your payment to the OCME at 450 Clarkson Ave, Box 1244 Brooklyn, NY 11203. Make check payable to SUNY OCME.
Please allow two weeks for a reply to your request, and indicate your choice of delivery of your request on the form. Transcripts and certificates will be forwarded upon receipt of your fee. If you have any questions, please refer your calls to (718) 270-2422.

For Office Use Only:

Date Received in OCME:_____ **Fee Paid:** ☐**Yes** **Pending:** ☐ **Mail Date**_____