SUNY DOWNSTATE Medical Center | Office of Continuing Medical Education

CME Certificate/Transcript Request

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/symposium, Date of Occurrence, Presented by (Hospital/Department):

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

Amount authorized: _____

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

*****3 digit security code**_____

Name & billing address_____

_____

Signature & Date _____

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

Delivery Method	☐ **Will pick-up** ☐ **E-mail to:**_____ ☐ **Fax#** _____
Mail to Address:	

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:**_____ **CME staff**_____

Date forwarded_____