SUNY Downstate Medical Center | Office of Continuing Medical Education

For credit card payment:

Date:	
Activity:	
Name of Registrant	

Credit Card information

Type of Card (check one)	☐ **MasterCard**	☐ **Visa**	☐ **Discover**
Card Number			
Exp. Date:			**3-Digit Security code**
Amount Authorized	$		
Name on card if different from registration			
Billing address			
Zip Code			
Contact Number			
E-mail			

Signature_____ Date _____

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

If paying by check, please mail your payment to: SUNY Downstate Medical Center, OCME Box 1244, 450 Clarkson Avenue, Brooklyn, NY 11203.