



**VERIFICATION OF TRAINING REQUEST FORM**

The Department of Radiological Sciences requests a payment of \$50.00 for each new Residency or Fellowship Verification of Training.

**Request By:** \_\_\_\_\_

\_\_\_\_\_

**RE:** \_\_\_\_\_

\*\*\*\*\*

Please make your check payable to: **UC Regents**

If you prefer to pay by credit card please fill out the following:

Date: \_\_\_\_\_

Credit Card Type:  VISA  MASTERCARD  DISCOVER  AMEX

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CSC/CVV: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

\_\_\_\_\_

Total Amount Paid: \_\_\_\_\_

**Fax or Mail: UC Irvine Medical Center  
Department of Radiological Sciences  
101 The City Drive South  
Bldg. 1, Suite 0115, Route 140  
Orange, CA 92868-3201  
Fax: 714-456-6832**

**Tax ID #: 95-2226406**