



Recurring Payment Authorization

Please complete the information below and return this form to Ultimate Medical Academy via fax at 1.800.611.3724, email to sfdocs@studymedical.com or by mail/in-person c/o Student Accounts, 9309 N Florida Ave, Tampa, FL 33612.

If you would like to cancel a recurring payment, please complete the first box and check here

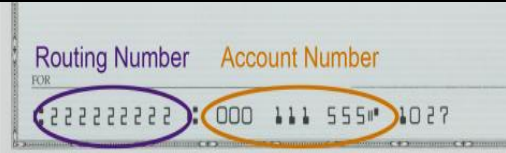
Name _____	Social Security # _____ (Merchant Order ID)
Phone Number _____	Zip Code _____
Email Address _____ (Required for email receipt)	

Initial (First) Payment Amount \$ _____	First Payment Date* _____ (mm/dd/yyyy)
Billing Cycle Frequency <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly	Max # of Billing Cycles _____ (Number of times recurring payment should occur)
Recurring Payment Date* <input type="checkbox"/> 1 st <input type="checkbox"/> 15 th	Recurring Payment Amt. \$ _____
* Date on or after which the debit to your account will occur (If blank, use CPP plan billing date)	

CHOOSE EITHER:

Exact Name on Credit Card _____
Credit Card Number _____ Expiration Date _____
CVV Number (Back of credit card) _____

OR

Exact Name linked to Checking or Savings Account _____
Account Number _____ <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Routing Number _____
How to find your Routing and Account Numbers


I hereby authorize Ultimate Medical Academy to either withdraw or charge regularly scheduled payments per the terms above. Proof of payment will appear on my billing statement. This authority remains in effect until the number of payments above is fulfilled or I notify UMA, in writing, to cancel the authorization (allowing 10 days for the change to take effect).

Signature _____ Date _____

**PLEASE KEEP A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS
SIGN AND FAX THIS FORM TO 1.800.611.3724**