



Recurring Payment Authorization

Please complete the information below and return this form to Ultimate Medical Academy via fax at 1.800.611.3724 or by mail/in-person c/o Continuing Student Finance, 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 [] Monthly [] Weekly	Max # of Billing Cycles _____ (Number of times recurring payment should occur)
Recurring Payment Date* [] 1 st [] 15 th	Recurring Payment Amt. \$ _____
* Date on or after which the debit to your account will occur (If blank, use CPP plan billing date)	

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

I hereby authorize Ultimate Medical Academy to 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**