

**INVOICE: Training Verification Fees**



Account ID: <i>Office Use Only</i>	Phone Number of Requesting Institute:	Date:
Name of Requesting Institution:	Contact Name:	Prepared By: <b>UC San Diego Education Services</b>
Contact email:	Address:	Preparer's Phone Number: <b>619-471-0728</b>
Fax:		

<b>Detail Code: RADVER</b>	
<b>TRAINING VERIFICATION FEES</b>	
<b>Program</b>	<b>Charge Amount</b>
Fellowship only:	\$130.00
Residency only:	\$130.00
Fellowship and Residency:	\$260.00
<b>Enter your Total:</b>	

<b>REMITTANCE INSTRUCTIONS</b>	
<b>IMPORTANT</b> – Print and return this invoice with your payment. <b>Make checks payable to: UC Regents</b>	
<b>USPS Mail to:</b> UCSD Radiology Business Office 9500 Gilman Drive, MC 0834 La Jolla CA 92093 Attn: Wendy Lemus	<b>OR</b>
<b>UPS/FedEx Mail to:</b> UCSD Radiology Business Office 410 Dickinson St, Suite 128 San Diego CA 92103 Attn: Wendy Lemus	
Name of physician to be verified:	Enter Total Fees Due (from above):

For questions regarding the status of your request, please contact [radverify@ucsd.edu](mailto:radverify@ucsd.edu)