

UNIVERSITY OF MEMPHIS  
MASTER OF PUBLIC HEALTH PROGRAM  
HEALTHCARE INTERPRETER CERTIFICATE PROGRAM  
**EMPLOYER PAYMENT FORM**

**Submit with payment. Please print clearly.**

Employer: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Mailing address: \_\_\_\_\_ Zip: \_\_\_\_\_  
Street City, State

Fax: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**PAYMENT INFORMATION**

**Registration Fee (please select one payment method) \$850.00**

BY CHECK:

Make checks payable to:  
University of Memphis

Send completed form and payment to:  
University of Memphis  
PO Box 1000, Department 313  
Memphis, TN 38148-0313

BY CREDIT CARD (MasterCard/VISA/DISCOVER):

Credit Card # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Fax credit card payments and completed form to: 901-678-2772 or mail to:  
University of Memphis  
115 Wilder Tower  
Memphis, TN 38152-3520

**PAYMENT FOR:**

Number of employees \_\_\_\_\_ @ \$850 = \_\_\_\_\_

This is payment for:

Employee Name(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**REFUND POLICY: NO REFUNDS WILL BE GIVEN UNLESS THE PROGRAM IS CANCELLED BY THE UNIVERSITY OF MEMPHIS.**

**BURSAR'S OFFICE USE ONLY:**  
FOAP: 127450/217160/51601/3200

Transaction Number: \_\_\_\_\_ Batch Number: \_\_\_\_\_

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