DICOE Payment Form(Part 3 of 3)

Master Facility Name *

Total facilities in your application *

1

Payment Type

If paying by check: The check must be payable to American College of Radiology. Please note, "DICOE Fee" on the memo line of the check.
Please mail a copy of your application along with the check to:

Diagnostic Imaging Center of Excellence
American College of Radiology
1891 Preston White Drive
Reston, VA 20191-4397

- ◯ Check
- ◯ Credit Card

Credit Card Information

If paying by credit card please fill out the form below. A member of the ACR will contact to process payment.

Card Type

Select

Name of Cardholder

Contact Person

Contact person telephone

Fax Number

Invoice *

If you require an invoice please send an email to

mferrara@acr.org

No

Please be sure to click on the box below to get a copy of your payment sheet for your records.

Send me a copy of my responses

Submit