



Arizona Medical Board

9545 E. Doubletree Ranch Road • Scottsdale, AZ 85258-5514
Telephone: 480-551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2704
Website: www.azmd.gov • E-Mail: questions@azmd.gov

NAME CHANGE FORM

License Number: _____

Full Legal Previous Name: _____

Full Legal New Name: _____

Reason for name change: (please attach legal documents)

Mail or fax this form along with your \$50.00 payment to: (if paying by credit card, please include the attached payment card authorization form)

**Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258
Fax: (480) 551-2704**

(Signature)

(Date)



Arizona Medical Board

**PAYMENT CARD AUTHORIZATION
NAME CHANGE FEE**

<p>Payment for: _____ MD Lic # _____ Physician Name</p> <p>NAME CHANGE FEE \$50</p> <p>Type of Card: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard</p> <p>Card #: <input type="text"/><input type="text"/><input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Expiration Date: <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> (MM-YY)</p> <p>Name as Shown on Payment Card: _____</p>
<p>Billing Address of Cardholder: (Required)</p> <p>Street Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Phone Number of Cardholder: _____ (Required)</p>
<p>Mailing Address of Cardholder: (If different from billing address):</p> <p>Street Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>
<p>Signature of Cardholder: _____ Date: _____</p>

Please complete and return this form *with legal documentation of name change* if paying by credit card.

Mail to: Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258
OR
Fax to: 480-551-2704