Arizona Medical Board

PAYMENT CARD AUTHORIZATION
DUPLICATE LICENSE FEE
(Wall certificate)

Payment for:_____,MD **Lic #_____**
Physician Name

DUPLICATE LICENSE FEE $50

Type of Card: ☐ **Visa** ☐ **MasterCard** ☐ **American Express**

Card #: ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

Expiration Date: ☐☐-☐☐ **(MM-YY)**

Name as Shown on Payment Card: _____

Billing Address of Cardholder:
(Required)

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number of Cardholder: _____
(Required)

Mailing Address of Cardholder: (If different from billing address):

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Signature of Cardholder: _____ **Date**:_____

Please complete and return this form *with your duplicate license request* if paying by credit card.
FAX: 480-551-2707 or
Mail to: Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258