Arizona Medical Board

PAYMENT CARD AUTHORIZATION
DUPLICATE LICENSE FEE: $50

(Wall Certificate)

Payment for: _____ **License #:** _____

(Physician Name)

Type of Card: ☐ **Visa** ☐ **Mastercard** ☐ **Amex**

Card Number: | | | | | | | | | | | | | | | | **Expiration Date:** _____

(No dashes between numbers)

Name as Shown on Payment Card: _____

Billing Address of Cardholder: _____
(Required)

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

Phone Number of Cardholder: _____
(Required)

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

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

Signature: _____ **Date:** _____

(Required)

Please complete and return this form with your duplicate license request if paying by credit card.

Mail to: **Arizona Medical Board**
1740 W. Adams St. Ste. 4000
Phoenix, AZ 85007-2664

Or Fax to: **(480) 551-2707**