



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: 480-551-2704 or

Mail to: Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258