



Arizona Medical Board

**PAYMENT CARD AUTHORIZATION
FOR DUPLICATE WALLET CARD**

Payment for: _____ MD Lic # _____ Physician Name	
DUPLICATE WALLET CARD FEE: \$10.00	
Type of Card: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express	
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"/>
Expiration Date:	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> (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 if paying by credit card.
Fax to 480-551-2704 or
Mail to: Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258