Arizona Board of Osteopathic Examiners In Medicine and Surgery
9535 E. Doubletree Ranch Road, Scottsdale, AZ 85258
Ph : 480-657-7703 | Fx: 480-657-7715 | www.azdo.gov | questions@azdo.gov

REQUEST FOR DUPLICATE LICENSE (WALL CERTIFICATE)

CREDIT CARD PAYMENT AUTHORIZATION

Name of Physician____, D.O. License No. _________________

This form and your order/application may be faxed to: 480-657-7715
If faxing this form, please do not mail the original as you may be charged twice.

DUPLICATE LICENSE FEE: $10.00

Type of Card: ☐ Visa ☐ MasterCard ☐ American Express

Visa or MasterCard #: ________________ - ________________ - ________________ - ________________

American Express #: ________________ - ______________________ - ________________

Expiration Date: ______________________ (MM/YY)

Name as Shown on Payment Card: ____

Billing Address: (Required)

Street Address: ____

City: ____ State: _________ Zip: ________________

Phone Number of Card Holder: (Required) ____

Mailing Address (Required if different from billing address)

Street Address: ____

City: ____ State: ________ Zip: _________________

Phone Number of Card Holder: (Required) ____

Signature of Cardholder: ____ **Date**: _________________

Note: ***The Board shreds this form after payment has been authorized by your credit card company***