



Arizona Board of Osteopathic Examiners In Medicine and Surgery

1740 W. Adams Street, Suite 2410, Phoenix, Arizona, 85007

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