Arizona Board of Osteopathic Examiners In Medicine and Surgery
1740 W. Adams, Suite 2410, Phoenix, Arizona 85007
Ph : 480-657-7703 | Fx: 480-657-7715 | www.azdo.gov | questions@azdo.gov

CREDIT CARD PAYMENT FORM

Name of Physician____ Date _______________
(if applicable)

Item/Service Requested: ____

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.

Amount: $_______________

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***