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

REQUEST FOR DUPLICATE LICENSE (WALL CERTIFICATE)

CREDIT CARD PAYMENT AUTHORIZATION

Name of Physician_____, D.O. License No. _____

We do not accept fax or email. Payment must be mailed with this request.

DUPLICATE LICENSE FEE: $10.00

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**: _____

Type of Card: ☐ Visa ☐ MasterCard ☐ American Express

Visa or MasterCard #: _____ - _____ - _____ - _____

American Express #: _____ - _____ - _____

Expiration Date: _____ (MM/YY)

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