PAYMENT CARD AUTHORIZATION
DUPLICATE LICENSE
WALL CERTIFICATE

Please utilize this form if paying with Credit Card.

PLEASE NOTE: The Arizona Medical Board will only accept credit card payment via mail

(USPS, FedEx, UPS, DHL, or any other mail carrier)

Any credit card information received via any other method will not be processed and will be destroyed.

Mail to:

Arizona Medical Board
1740 W Adams St, Suite 4000
Phoenix, AZ 85007

PA Wall Certificate Fee: $25

First Name: _____ Last Name: _____

Name as Shown on Payment Card: _____

Cardholder Signature: _____ Date: _____
(Required)

Billing Address of Cardholder: _____
(Required)

City: _____ State: _____ Zip Code: _____

Contact Phone: _____

Mailing Address of Cardholder: _____
(If Different from Billing Address)

City: _____ State: _____ Zip Code: _____

Last 4 Digits of Payment Card

_____

For receipt, please include an email address for submissions: _____

Type of Card: ☐ Visa ☐ Mastercard ☐ Amex

Card Number: _____ Expiration Date: _____