



ARIZONA BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE & SURGERY

9535 E. Doubletree Ranch Road, Scottsdale, AZ 85258-5572
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: _____

Please complete and return this form and your order/application if paying by credit card.

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.

Due to the cost of processing credit cards, we do not accept credit card payments under \$25.00.

If the service you are requesting costs less than \$25, please send a check or money order with your written request or order form.

Amount: \$ _____ + \$8.00* = \$ _____
Total

***An \$8.00 processing fee is required for ALL credit card transactions**

Type of Card: Visa MasterCard American Express

Visa or MasterCard #: - - -

American Express #: - -

Expiration Date: _____ / (Month Name/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