Verification of Certification Request Form

Please supply the following information regarding the physician or physicist whose certification is to be verified:

Name: _____

Date of birth: _____

Last 4 digits of social security number: _____

Address to which this information should be sent: _____

_____

_____

Mail or fax this form to:

The American Board of Radiology
5441 East Williams Blvd., Suite 200
Tucson, AZ 85711
Phone (520) 790-2900
Fax (520) 790-3200

Credit Card Form

Exact name that appears on credit card: _____

The following information must be as it applies to billing of the credit card:

Billing address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ - _____-_____

Visa ☐ MasterCard ☐

CC#:

				-					-					-				

Expiration date: _____ Amount authorized: $100.00

Signature of card holder: _____

If your payment is declined <u>for any reason</u>, there will be a $100.00 processing fee.