The American Board of Radiology
Certificate Request Form

Name: _____

Date of birth: _____

Address to which the certificate should be sent: _____

_____

_____

Email address or phone number: _____

Type of Request:

- ☐ Duplicate
- ☐ Replacement

If your original certificate needs to be replaced, please state the reason:

_____

Type of Certificate:

- ☐ Initial Certificate
- ☐ Maintenance of Certification

Please check below all that apply towards the certificate you are requesting:

- ☐ Diagnostic Radiology
- ☐ Radiation Oncology
- ☐ Radiologic Physics
- ☐ Subspecialty: _____
- ☐ Other: _____

Diplomate's Signature: _____

CREDIT CARD FORM

Name of cardholder: _____

Mailing address on card: _____

_____

Phone number of cardholder: _____-_____-_____

Visa □ MasterCard □

CC#:

				-					-					-				

Expiration date: _____ Amount: **$100.00**

Signature: _____

Fee Code: _____ (For office use only)

A debit card is not an accepted form of payment.
If a credit card is declined for any reason, there will be a $100.00 processing fee.

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