

The American Board of Radiology

Verification Request Form

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

Name: _____

Date of Birth: _____

Organization/Institution to which this information should be sent:

Address to which this information should be sent: _____

Mail this form to: The American Board of Radiology
 5441 East Williams Blvd., Suite 200
 Tucson, AZ 85711

If you wish, you may fax this form and pay by credit card. Fax: (520) 790-3200

CREDIT CARD FORM

Name of cardholder: _____

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Visa MasterCard

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Expiration date: _____ Amount: \$ _____

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.**