ABR | AMERICAN BOARD OF RADIOLOGY

Certificate Request Form

Name: _____ Date of Birth: _____

Address to which document should be sent: _____

_____

Email address _____

Phone number: _____ ABR ID number (if known): _____

☐ Duplicate ☐ Replacement

Type of Certificate: ☐ Initial Certificate ☐ Maintenance of Certification

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

☐ Diagnostic Radiology ☐ Radiation Oncology ☐ Medical Physics

☐ Subspecialty _____ ☐ Other _____

PAYMENT OPTIONS

Please note that the ABR cannot accept credit card forms by email.

☐ Check ☐ VISA ☐ MasterCard ☐ American Express

Name as it appears on your credit card: _____

Credit Card Billing Address: _____

City: _____ State: _____ Zip Code: _____

Credit Card# *(no spaces)*:

Expiration Date: _____ Amount Authorized: $100.00

Signature of Cardholder: _____

If your payment is declined for any reason, there will be a $100 processing fee.

Mail or fax this form to: THE AMERICAN BOARD OF RADIOLOGY
5441 E. WILLIAMS CIRCLE, TUCSON, AZ 85711
FAX: (520) 790-3200