ABR | AMERICAN BOARD OF RADIOLOGY

ABR CERTIFICATE REQUEST FORM

Name:_____ Date of birth:_____

Address to which document should be sent:_____

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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 ☐ Interventional Radiology/Diagnostic Radiology ☐ Radiation Oncology ☐ Medical Physics

☐ Subspecialty_____ ☐ Other_____

PAYMENT OPTIONS

☐ Check ☐ Visa ☐ Master Card ☐ American Express

CREDIT CARD INFORMATION

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

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

Signature of cardholder: _____

Mail or fax this form to: The American Board of Radiology
5441 East Williams Circle
Tucson, AZ 85711
Fax: (520) 790-3200

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