



Verification Request Form

Name: _____ Date of Birth: _____

Address to which document should be sent: _____

Email address _____

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

Is the verification letter for state licensing/permit purposes? Yes No

If yes, does the letter need to include your previous exam results? Yes No

If yes, please note that by submitting this request, you are authorizing the ABR to release all exam results, including pass and fail results.

If this request is from a third party, and you are requesting the verification to include exam results, a signed release from the candidate/diplomate must be provided along with this request.

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: _____

Self-Verification: \$30.00 Third-Party Verification: \$100.00 Amount Authorized: \$ _____

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