

# CREDIT CARD AUTHORIZATION FORM

*If mailing or faxing this page separately from an application or order form, please mail to:  
Nevada State Board of Medical Examiners  
1105 Terminal Way, Suite 301, Reno, NV 89502-2144  
or fax to:  
775-688-2321*

**Please type or print legibly.**

Method of Payment:     MasterCard     Visa     American Express     Discover

Name on Credit Card: \_\_\_\_\_

Business Name (if applicable): \_\_\_\_\_

Credit Card Billing Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Name of Applicant/Licensee (if applicable): \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_  
                          (MM)    (YYYY)

***For security of your financial information, please do not email this form to the Board; emailed forms will not be accepted.***

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time payment in the amount of \$ \_\_\_\_\_, and an additional 2% service fee.

Printed Name: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_