Nevada State Board of Medical Examiners
9600 Gateway Drive, Reno, NV 89521
Phone: In Reno/Sparks/Carson City: (775) 688-2559
(If calling from any other area of Nevada, call the Board's in-state toll-free number: (888) 890-8210))
Fax: (775) 688-2321

REQUEST FOR REPLACEMENT WALL CERTIFICATE AND/OR WALLET IDENTIFICATION CARD

Please complete and mail this form to: Nevada State Board of Medical Examiners
9600 Gateway Drive, Reno, NV 89521

You must submit a copy of your photo ID with your request in order to verify your identity to ensure your information is released only to you.

Date: ____________________________

Name: ____

License No.: ___________________________

Please send:

- ☐ Replacement Wall Certificate....................................$25.00
- ☐ Replacement Wallet ID Card....................................$15.00

To the address below:

Street/P.O. Box: ____

City, State Zip: ____

Reason for Replacement: ____

____

____ Signature (required)

____________________ Date

Payment must be made in advance. You may pay by cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization Form on the last page of this form. A 2.5% payment-processing fee will be assessed for payment by credit card.

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
9600 Gateway Drive
Reno, NV 89521
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 (if applying for licensure): ____

Credit Card Number: ____

Expiration Date: _____ / _____ Credit Card Verification Code (CVC): _____
(MM) (YYYY) *(Three or four digit code found on the front or back of the card)*

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 $______________.

Printed Name: ____

Authorized Signature: ____Date:__________

Email Address for receipt: ____

Disclosure: By continuing, you will be charged a non-refundable card payment-processing fee of 2.5% for debit and credit cards by our payment processor. If you do not wish to pay the fee, you can select another payment option.