

Nevada State Board of Medical Examiners
1105 Terminal Way, Suite 301, Reno, NV 89502-2144
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
1105 Terminal Way, Suite 301, Reno, NV 89502-2144

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 check, 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 two percent (2%) service 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
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: _____

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: _____