

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:

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Name of Applicant (if applying for licensure): _____

Credit Card Number: _____

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Credit Card Verification Code (CVC): ____
(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.