Nevada State Board of Medical Examiners

9600 Gateway Drive, Reno, NV 89521
Phone: (775) 688-2559; (888) 890-8210 (Toll-Free)
Fax: (775) 688-2321

REQUEST FOR REPLACEMENT WALL CERTIFICATE

Please complete and mail or fax this form to:

Nevada State Board of Medical Examiners
9600 Gateway Drive, Reno, NV 89521
Fax: (775) 688-2321

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

Date: _____

Name: _____

License No.: _____

Please send replacement Wall Certificate to the address below:

Street/P.O. Box: _____

City, State Zip: _____

Reason for Replacement: _____

_____

_____ _____
Signature (required) Date

PAYMENT: 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. The Board cannot accept personal or business checks. If paying by credit card, please complete the Credit Card Authorization Form on the last page of this order form. A non-refundable card payment-processing fee of 2.5% will be assessed by our payment processor 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
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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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Phone Number: _____

Name of Applicant (if applying for licensure): _____

Credit Card Number: _____

Expiration Date: _____ / _____ *(MM) (YYYY)*

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.