American Board of Psychiatry and Neurology, Inc.
A Member Board of the American Board of Medical Specialties (ABMS)

Request for Duplicate Certificate Form

Fee $150 - check or credit card accepted (payment form included)
Please note: Photocopies of Board certificates are not available from the ABPN

☐unframed certificate (approx. 11” x 14”)

Indicate the specialty or subspecialty: _____

Indicate type: ☐Initial Certification ☐Maintenance of Certification

Full Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Email: _____ Telephone: _____ Fax: _____

Birth Date: _____

Name and title as it should be printed on the certificate:

_____

Please note: For any name changes on a certificate, please submit certified, legal documentation (marriage license, name change determination, etc.) with this form.

Documentation that must be included:

☐copies of all medical licenses held or the current renewal registration cards for your medical licenses, *whichever show the expiration date,*

☐for security purposes, a copy of government-issued photo identification, such as a driver’s license or passport, and

☐the $150 fee payable to the American Board of Psychiatry and Neurology, Inc.

I realize that certificates are printed approximately four times per year. Depending on when a duplicate certificate is requested, it may be four to six months until I receive the duplicate certificate.

Signature: _____ Date: _____

ABPN
7 Parkway North
Deerfield, IL 60015
Phone: 847.229.6500
Fax: 847.229.6600

The American Board of Psychiatry and Neurology, Inc. accepts payment by American Express, Discover, Mastercard or Visa credit cards. Please fill in all requested information and return via mail to the address listed above or fax to 847.229.6600. If you received a billing statement or letter informing you of fees to be paid, you must include a copy of the letter with your payment, or attach the appropriate billing statement or order form.

The ABPN accepts no liability for misdirected or inaccurate information. If you submit this information via facsimile transmission, please include a Disclaimer in your fax transmission such as the one provided below:

Disclaimer: This facsimile transmission contains information, which is confidential and/or privileged. This information is intended for use only by the addressee indicated above. If you are not the intended recipient, please be advised that any disclosure, copying, distribution, or use of the contents of this information is strictly prohibited, and that any misdirected or improperly received information must be returned to the sender immediately.

PLEASE PROVIDE ALL CREDIT CARD INFORMATION

☐American Express ☐Discover ☐Mastercard ☐Visa Credit Card No. _____

Amount Authorized for payment: $ _____ Expiration Date (mm/yy) _____

Name as shown on Credit Card: _____

Billing Address: _____

City, State, Zip: _____

Billing Phone No: _____

Signature of Credit Card holder: _____