



MEDICAL BOARD OF WESTERN AUSTRALIA

ABN: 25 271 541 367

APPLICATION FOR DUPLICATE CERTIFICATE OF REGISTRATION

I,	
(Full name in block letters - underline Surname)	
Registration Number:	
Request for a duplicate certificate of registration to be issued to the following address:	
Postal Address:	
<input type="checkbox"/> I attach payment of \$30.00 (cheque or money order, credit card, <i>see below</i>) for the duplicate certificate of registration to be made payable to "Medical Board of Western Australia"	
this _____ day of _____ 20____	
_____ <i>Signature of Applicant</i>	

PAYMENT BY CREDIT CARD (VISA OR MASTERCARD)			
Name on Card			
Card number	- - -		
	<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	Expiry
Signature of Cardholder:			