FOR OFFICE USE:

Date/Time Rec'd: _____ CSR/PA _____
Date Payment Rec'd _____ CSR/PA _____
Date Duplicate Processed _____ CSR/PA _____

Wake AHEC

REQUEST FOR DUPLICATE CE CREDIT CERTIFICATE

Please **PRINT** legibly.

Date of Program: _____ **Name of Program:** _____

PIN: | | | | | Salutation: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

(The 4 digit PIN that you used when you registered.)

NAME: (First) _____ (MI) ___ (Last) _____

_____
Home Mailing Address City State Zip

Home County: _____ Phone: (_____) _____

Employment Information

Employer's or Practice Name: _____

_____
Employer's Mailing Address City State Zip

Work County: _____ E-Mail: _____

Phone: (_____) _____ Fax: (_____) _____

Job Title: _____ Occupation/Discipline: (e.g., Oncology, Internal Medicine) _____

Degree(s) (e.g., MD, MS, BS): _____ Credential(s) (e.g., CDE, LDN, RN, NP, PA): _____

Duplicate Certificate Fee $15.00 (due at time of request)

Payment Options:

Credit Card: ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover Card ☐ Check Enclosed (Make checks payable to Wake AHEC.)

Credit Card #: _____ Expiration Date: _____

Name as it appears on credit card: *(Please print)* _____

Signature of Authorized Cardholder: _____

- To request a duplicate certificate with credit card: **FAX** (919) 350-0467
- To request duplicate certificate with check: Mail request to: Wake AHEC, Attn: Registrar
  3261 Atlantic Avenue, Suite 212
  Raleigh, NC 27604-1657

Duplicate Certificate will be processed upon receipt of payment.

How do you prefer to receive your certificate? ☐ Fax **OR** ☐ Mail (☐ Home ☐ Work)