



ARDMS®
The globally recognized standard
of excellence in sonography

DUPLICATE SCORE REPORT REQUEST FORM

(examination date prior to 2000)

This form must be completed in its entirety. Please print or type all information and include a check, money order, credit card (section at the bottom of this form) in the amount of \$25.00 UDS (for each score report requested). Please allow 10 business days for the report to be sent to you via mail. The Duplicate Score Report Form will be returned due to incomplete information, failure to sign the form or pay the fee.

Date _____ ARDMS Number _____

Name _____

Address _____

City _____ State _____ ZIP/Postal Code _____

Country _____ E-mail _____

Home Phone _____ Work Phone _____

Examination Name _____ Examination Date _____

Payment Information

Payment: \$25 US Dollars (for each score report requested)

Enclosed: Check (payable to ARDMS)

Money Order (payable to ARDMS)

MasterCard

VISA

Discover

Card number: _____ / _____ / _____ / _____

Expiration Date (month/year) _____ / _____

Cardholder Name _____

I certify that the information provided above is correct.

Signature _____ Date _____

Your request will not be processed without a signature

Mail this form with check or money order to:
ARDMS
ATTN: Duplicate Score Report
51 Monroe Street, Plaza East One
Rockville, MD 20850-2400

Fax this form with credit card payment to:
ARDMS
ATTN: Duplicate Score Report (301) 738-0312

ARDMS OFFICIAL USE ONLY

Received _____

Sent to Accounting _____