

B READER SCHEDULING FORM
(PLEASE PRINT)

DATE:				
FIRST NAME:				
LAST NAME:				
MI:	INITIALS:	M.D.	D.O.	BIRTHDATE: (MM/DD/YYYY)
PLACE OF BIRTH: (CITY AND STATE OR CITY AND COUNTRY)				
IDENTIFICATION TYPE: (SELECT ONE)				
<input type="checkbox"/> DRIVER'S LICENSE (REAL ID-COMPLIANT)	ID NUMBER: _____			
<input type="checkbox"/> IDENTIFICATION CARD (REAL ID-COMPLIANT)	ID NUMBER: _____			
HOSPITAL OR DEPT (OPTIONAL):				
STREET ADDRESS 1:				
STREET ADDRESS 2:				
CITY:		STATE:	ZIP CODE:	
US CITIZEN?	YES	NO	COUNTRY (IF NOT US):	
TELEPHONE 1:		TELEPHONE 2:		
EMAIL:		EXAM TYPE: INITIAL RECERT		
EXAM DATE CHOICE 1:		EXAM DATE CHOICE 2:		
MEDICAL LICENSE#:		STATE ISSUED:		
YOU WILL NEED TO PROVIDE A COPY OF YOUR CURRENT MEDICAL LICENSE TO KEEP ON FILE (IF LICENSED IN MULTIPLE STATES, PROVIDING ONLY ONE IS NECESSARY)				

SIGNATURE: _____ DATE: _____

YOU MUST HAVE A REAL ID APPROVED DOCUMENT
when scheduling your exam at the Morgantown NIOSH facility