

B READER SCHEDULING FORM
(PLEASE PRINT)

DATE:				
FIRST NAME:			LAST NAME:	
MI:	INITIALS:	M.D. <input type="checkbox"/>	D.O. <input type="checkbox"/>	BIRTHDATE: (MM/DD/YYYY)
PLACE OF BIRTH: (CITY AND STATE OR CITY AND COUNTRY)				
IDENTIFICATION TYPE: (SELECT ONE)				
<div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> DRIVER'S LICENSE (REAL ID-COMPLIANT)</div><div>ID NUMBER: _____</div></div>				
<div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> IDENTIFICATION CARD (REAL ID-COMPLIANT)</div><div>ID NUMBER: _____</div></div>				
HOSPITAL OR DEPT (OPTIONAL):				
STREET ADDRESS 1:				
STREET ADDRESS 2:				
CITY:		STATE:	ZIP CODE:	
US CITIZEN? YES NO <div style="display: flex; justify-content: space-around;"><input type="checkbox"/> <input type="checkbox"/></div>		COUNTRY (IF NOT US):		
TELEPHONE 1:		TELEPHONE 2:		
EMAIL:			EXAM TYPE: INITIAL RECERT <div style="display: flex; justify-content: space-around;"><input type="checkbox"/> <input type="checkbox"/></div>	
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