

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	ID NUMBER	EXPIRATION DATE
<input type="checkbox"/> DRIVER'S LICENSE (REAL ID-COMPLIANT)		
<input type="checkbox"/> PASSPORT		
<input type="checkbox"/> OTHER		

HOSPITAL OR DEPT (OPTIONAL):

STREET ADDRESS 1:

STREET ADDRESS 2:

CITY:

STATE:

ZIP CODE:

US CITIZEN? YES NO

COUNTRIES WHERE YOU HOLD CITIZENSHIP (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 FILE
(IF LICENSED IN MULTIPLE STATES, SUBMITTING ONE IS SUFFICIENT)

SIGNATURE: _____ DATE: _____

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