Attachment 12 –

Physician Application for Certification – Form 2.12

Form Approved

OMB No.: 0920-0020

Exp. Date xx/xx/20xx

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| **PHYSICIAN APPLICATION FOR CERTIFICATION**  Department of Health and Human Services  Centers for Disease Control and Prevention  National Institute for Occupational Safety and Health | | | | | | | | | | STATUS | | | FOR NIOSH USE ONLY | | | | | | | | | |
| RETURN  TO | | | NIOSH  Coal Workers’ Health Surveillance Program  1095 Willowdale Road, M/S LB208  Morgantown, WV 26505  FAX: 304-285-6058 | | | | | | | | | ACTIVE STATE LICENSE(S)  State: \_\_\_\_\_\_ License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State: \_\_\_\_\_\_ License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State: \_\_\_\_\_\_ License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| SOCIAL SECURITY NUMBER  (Full SSN is optional; last 4 digits are required) | | | | | | | | | | | | | | | | | | | | | | |
| NAME (LAST-FIRST-MIDDLE) | | | | | | | | | | | | | | INITIALS | | | | | | DATE OF BIRTH | | |
| HOSPITAL OR DEPARTMENT | | | | | STREET ADDRESS | | | | | | | | | | | | | | | | | |
| CITY | | | | | STATE | | | ZIP CODE | | | | | | | | | COUNTRY | | | | | |
| TELEPHONE NUMBER | | | | | | | | EMAIL ADDRESS | | | | | | | | | | | | | | |
| During the last year, average number of chest radiographs viewed and assessed per month: \_\_\_\_\_\_  During the last year, average number of chest radiographs classified according to ILO system per month: \_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | |
| SPECIALITY: | | Primary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Secondary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Board Certified? | | | | | | | | Primary | | Yes | | | | No |
| Secondary: | | Yes | | | | No |
|  | I am applying to be an A Reader, and | | | | | | | | | | | | | | | | | | | | | |
|  | I am submitting six chest radiographs, along with my classifications performed according the *Guidelines*  *for the use of the ILO International Classification of Radiographs of Pneumoconioses*; or | | | | | | | | | | | | | | | | | | | | | |
|  | I have taken instruction in the current edition of the *ILO International Classification of Radiographs of*  *Pneumoconioses*  I attended the approved course at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City Date | | | | | | | | | | | | | | | | | | | | | |
|  | I am applying to be a B Reader, and | | | | | | | | | | | | | | | | | | | | | |
|  | I have most recently taken the B Reader Certification exam at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_\_\_\_\_  City Date | | | | | | | | | | | | | | | | | | | | | |
|  | I have most recently taken the B Reader Recertification exam at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_\_\_\_\_\_  City Date | | | | | | | | | | | | | | | | | | | | | |
|  | I want my name and contact information included on the CDC Internet listing of physicians who have demonstrated competence in applying the ILO classification by successfully completing the NIOSH B Reader examination. | | | | | | | | | | | | | | | | | | | | | |
| Are you employed by a Federal Government Agency? | | | | | | | | | | | Yes | | | | No | | | | | | | |
| If so, which one and where is your duty station? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| Would you be interested in classifying chest radiographic images for NIOSH programs (e.g. the Coal Workers’ | | | | | | | | | | | | | | | | | | | | | | |
| Health Surveillance Program)? | | | | | | Yes | | | | | No | | | | | | | | | | | |
| Do you anticipate that you will use this certification to document your credentials to classify chest radiographs for | | | | | | | | | | | | | | | | | | | | | | |
| other (non-NIOSH) programs or purposes? | | | | | | | | | | | | | | | | | | | | | | |
| Government Programs | | | | Yes | No | | | | Medical-Legal Activities | | | | | | | | | | Yes | | No | |
| Individual Patient Care | | | | Yes | No | | | | Occupational Health Programs | | | | | | | | | | Yes | | No | |
| Investigations / Research | | | | Yes | No | | | | Other (describe below) | | | | | | | | | | Yes | | No | |
|  | | | |  | | |  | | | | |  | | | | | | |  | |  | |
| Describe “other” activity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | |

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| I agree that I will abide by the B Reader Code of Ethics when classifying chest radiographic images. If I participate in  the Coal Workers’ X-Ray Surveillance Program, my performance will be conducted in the manner specified by HHS  regulation 42 C.F.R. Part 37, and I understand that information related to classifications of individual radiographs  made in connection with this program will be treated in a secure manner and will not be disclosed, unless otherwise compelled by law. I further understand that: 1) My B Reader certification requires an active license to practice  medicine in the United States and I must notify the NIOSH B Reader Program within 60 days if my medical license is  revoked, suspended, voluntarily relinquished or surrendered, or converted to inactive status\*; 2) NIOSH does not  regulate or monitor my classification of chest images performed for non-NIOSH purposes; 3) If NIOSH becomes  aware of violations, or allegations of violations, of the B Reader Code of Ethics, it may, at its discretion, notify  appropriate authorities, including the applicable State Board(s) of Medicine.  \*Send written notification to:  NIOSH Coal Workers’ Health Surveillance Program, 1095 Willowdale Road, M/S LB208, Morgantown, WV 26505 | | | | | | |
| DATE | | PHYSICIAN SIGNATURE | | | | |
| **FOR NIOSH USE ONLY** | | | | | | |
| CERT DATE | DATE OF EXAM | | TYPE OF EXAM  B R | SCORE | STUDY METHOD  A B C D | EXAM SITE |
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| Public reporting burden of this collection of information is estimated to average 10 minutes per response, including  the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and  completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not  required to respond to a collection of information unless it displays a currently valid OMB control number. Send  comments regarding this burden estimate or any other aspect of this collection of information, including  suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA  30333, ATTN: PRA (0920-0020). Do not send the completed form to this address. | | | | | | |

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