Form Approved

OMB No.: 0920-0020

Exp. Date 09/30/2021

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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 | | | | | | | |
|  | NIOSH  Coal Workers’ Health Surveillance Program (CWHSP)  1000 Frederick Lane, M/S LB208  Morgantown, WV 26508  FAX: 304-285-6058 | | | | | | ACTIVE STATE LICENSE(S)  State: \_\_\_\_\_\_ License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State: \_\_\_\_\_\_ License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State: \_\_\_\_\_\_ License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| NIOSH READER ID | | | | | | | | | | | | | | | |
| 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. | | | | | | | | | | | | | |
|  | | Do not show any contact information on the internet (name and state only).  Use the same contact Information as provided above for the internet.  Use the following contact information on the internet. | | | | | | | | | | | | | |
| HOSPITAL OR DEPARTMENT | | | | | | | | | | | | | |
| STREET ADDRESS | | | | | | | | | | | | | |
| CITY | | | STATE | | | | | | | ZIP CODE | | | |
| COUNTRY | | | TELEPHONE NUMBER | | | | | | | | | | |
| EMAIL ADDRESS | | | | | | | | | | | | | |

CDC 2.12 (E), Rev. 03/2021

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| 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. CWHSP) Yes  No | | | | | | | | | | | | | |
| Do you hold an active academic teaching appointment at a U.S. medical school? Yes  No  If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| 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’ Health 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, 1000 Frederick Lane, M/S LB208, Morgantown, WV 26508 | | | | | | | | | | | | | |
| 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 | | | | | | | EXAM FORMAT  A D | | | |
| 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-24, Atlanta, GA  30333, ATTN: PRA (0920-0020). Do not send the completed form to this address. | | | | | | | | | | | | | |

CDC 2.12 (E), Rev. 03/2021