

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: _____	Board Certified?	Primary	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Secondary: _____		Secondary:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<input type="checkbox"/>	I am applying to be an A Reader, and <input type="checkbox"/> I am submitting six chest radiographs, along with my classifications performed according the <i>Guidelines for the use of the ILO International Classification of Radiographs of Pneumoconioses</i> ; or <input type="checkbox"/> I have taken instruction in the current edition of the <i>ILO International Classification of Radiographs of Pneumoconioses</i> I attended the approved course at: _____ on _____ <div style="display: flex; justify-content: space-around; width: 100%;"> City Date </div>				
<input type="checkbox"/>	I am applying to be a B Reader.				
<input type="checkbox"/>	Do not show any contact information on the internet (name and state only).				
<input type="checkbox"/>	Use the same contact information as provided above for the internet.				
<input type="checkbox"/>	Use the following contact information on the internet.				
	HOSPITAL OR DEPARTMENT				
	STREET ADDRESS				
	CITY	STATE	ZIP CODE		
	COUNTRY	TELEPHONE NUMBER			
	EMAIL ADDRESS				

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 <input type="checkbox"/>	No <input type="checkbox"/>	Medical-Legal Activities	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Individual Patient Care	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Occupational Health Programs	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Investigations / Research	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other (describe below)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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
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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.