Form Approved
OMB No.: 0920-0020

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 ☐ No ☐
Secondary: _____ 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

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	