| DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH | | | | | | FOR NIOSH USE ONLY | | |
|--|----------|--|--|-----------------|---|--------------------|-----------|--|
| INTERPRETING PHYSICIAN CERTIFICATION DOCUMENT | | | | | | | | |
| NIOSH | | | | | MEDICAL LICENSE NUMBER | | | |
| RETURN TO | | oal Workers' Health Surveillance Program DBOX 458 | | | | OTATE LIGENOED IN | | |
| MORGANTOWN, WEST VIRGINIA 26504 | | | | | STATE LICENSED IN | | | |
| NAME (LAST-FIRST-MIDDLE) | | | | | SOCIAL SECURITY NUMBER DATE OF BIRTH | | | |
| HOSPITAL OR DEPARTMENT STREET A | | | | | DDRESS | | | |
| TIOOI TIAL C | JK DEI A | WY TIVILIVI | DDINEGO | | | | | |
| CITY STATE | | | | | ZIP CODE | | | |
| | | | | | | | | |
| | | | r, monthly average st films interpreted per | Chest films int | terpreted for ses per month Chest films interpreted for other occupational respiratory disease per month | | | |
| SPECIALTY | Prim | ary | Board | I Certified? | Prim | nary Yes_ | No | |
| Secondary | | | | | | econdary Yes No | | |
| I am applying to be a first or "A" reader, and I choose to submit six ILO-U/C classified films for review I have taken instruction in the ILO-U/C classification system I attended the approved course at: on | | | | | | | | |
| I am applying to be a first or "B" reader, and | | | | | | | | |
| | | | I have taken the "B" Reader Proficiency exam at: on date | | | | | |
| | | | | | | | | |
| I have taken the "B" Reader Recertification exam at: on city date | | | | | | | | |
| Do you anticipate that you will use this certification to interpret radiographs for occupational lung disease for: Individual patient care Government programs Industry programs Medical-legal activities Would you be interested in participating as a B Reader for the National Coal Workers' Xray Surveillance Program? | | | | | | | | |
| Yes No | | | | | | | | |
| I agree that my participation in the X-Ray Surveillance Program for Underground Coal Miners will be conducted in the manner specified by Part 37, Title 42 of the Code of Federal Regulations, and understand that all information related X-Ray Interpretations made in connection with this Program will be held STRICTLY CONFIDENTIAL and divulged only as specified by the above Regulation. | | | | | | | | |
| DATE PHYSICIAN SIGNATURE | | | | | | | | |
| *Social Security Number is furnished solely for purpose of identification and reimbursement. It will be treated as confidential information and released only with permission of the provider. | | | | | | | | |
| FOR ALOSH USE ONLY | | | | | | | | |
| CERT DATE | | DATE OF EXAM | TYPE OF EXAM SC | ORE | STUDY METH | HOD | EXAM SITE | |
| | | | B R | | Α | B C D | | |
| | | | | | | | | |

CDC/NIOSH (M) 2.12(E), 07/2007, CDC Adobe Acrobat 5.0 Electronic Version, 3/2005

Public reporting burden of this collection of information is estimated to average 30 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.