B Reader Scheduling Form
(Please Print)

Date:			
Last Name:			
First Name:			
MI:	Initials:	M.D. ☐ D.O. ☐	Birthdate:
Hospital or Dept (optional):			
Street Address 1:			
Street Address 2:			
City:	State:	Zip Code:	
US Citizen? Yes ☐ No ☐	Country (If Not US):		
Telephone 1:	Telephone 2:		
Email:	Exam Type? Initial ☐ Recert ☐		
Exam Date Choice 1:	Exam Date Choice 2:		
Medical License#:	State Issued:		

You will need to provide a copy of your current medical license to keep on file
(If licensed in multiple states, providing only one is necessary)

Signature: _____ Date: _____

Please ensure you have a Real ID approved document
when scheduling your exam at the Morgantown NIOSH facility.