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: _____