

3. Personnel (Technicians) who Perform Tests

This section is to be completed with information about all non-physician personnel who perform tests for this IDTF. If there are more than six technicians, copy and complete this section as needed.

A. 1st Personnel (Technician) Information ☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name	First	Middle	Last	Jr., Sr., etc.
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Social Security Number	Date of Birth (MM/DD/YYYY)
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2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
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State of Issuance (if applicable)	Type of License/Certification (if applicable)
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3. Is this technician certified by a national credentialing organization? ☐ YES ☐ NO

Name of credentialing organization (if applicable)	Type of Credentials (if applicable)
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4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here: _____

B. 2nd Personnel (Technician) Information ☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name	First	Middle	Last	Jr., Sr., etc.
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Social Security Number	Date of Birth (MM/DD/YYYY)
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2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
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State of Issuance (if applicable)	Type of License/Certification (if applicable)
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3. Is this technician certified by a national credentialing organization? ☐ YES ☐ NO

Name of credentialing organization (if applicable)	Type of Credentials (if applicable)
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4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here: _____

C. 3rd Personnel (Technician) Information ☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name	First	Middle	Last	Jr., Sr., etc.
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Social Security Number	Date of Birth (MM/DD/YYYY)
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2. Is this technician State licensed or State certified? ☐ YES ☐ NO

License/Certification Number (if applicable)	License/Certification Issue Date (if applicable) (MM/DD/YYYY)
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State of Issuance (if applicable)	Type of License/Certification (if applicable)
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3. Is this technician certified by a national credentialing organization? ☐ YES ☐ NO

Name of credentialing organization (if applicable)	Type of Credentials (if applicable)
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4. Is this technician employed by a hospital? ☐ YES ☐ NO
IF YES, furnish the name of the hospital here: _____