

OMB Approval No. 0938-0685

3. Personnel (Technicians) who Perform Tests (Continued)				
D. 4 th Personnel (Technician) Information <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change Effective Date: _____				
1. Name	First	Middle	Last	Jr., Sr., etc.
Social Security Number			Date of Birth (MM/DD/YYYY)	
2. Is this technician State licensed or State certified? <input type="checkbox"/> YES <input type="checkbox"/> NO				
License/Certification Number (if applicable)			License/Certification Issue Date (if applicable) (MM/DD/YYYY)	
State of Issuance (if applicable)			Type of License/Certification (if applicable)	
3. Is this technician certified by a national credentialing organization? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Name of credentialing organization (if applicable)			Type of Credentials (if applicable)	
4. Is this technician employed by a hospital? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, furnish the name of the hospital here: _____				
E. 5 th Personnel (Technician) Information <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change Effective Date: _____				
1. Name	First	Middle	Last	Jr., Sr., etc.
Social Security Number			Date of Birth (MM/DD/YYYY)	
2. Is this technician State licensed or State certified? <input type="checkbox"/> YES <input type="checkbox"/> NO				
License/Certification Number (if applicable)			License/Certification Issue Date (if applicable) (MM/DD/YYYY)	
State of Issuance (if applicable)			Type of License/Certification (if applicable)	
3. Is this technician certified by a national credentialing organization? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Name of credentialing organization (if applicable)			Type of Credentials (if applicable)	
4. Is this technician employed by a hospital? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, furnish the name of the hospital here: _____				
F. 6 th Personnel (Technician) Information <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change Effective Date: _____				
1. Name	First	Middle	Last	Jr., Sr., etc.
Social Security Number			Date of Birth (MM/DD/YYYY)	
2. Is this technician State licensed or State certified? <input type="checkbox"/> YES <input type="checkbox"/> NO				
License/Certification Number (if applicable)			License/Certification Issue Date (if applicable) (MM/DD/YYYY)	
State of Issuance (if applicable)			Type of License/Certification (if applicable)	
3. Is this technician certified by a national credentialing organization? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Name of credentialing organization (if applicable)			Type of Credentials (if applicable)	
4. Is this technician employed by a hospital? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, furnish the name of the hospital here: _____				