

Instructions & Sample Test Report:

Open and print

NIOSH
Coal Workers' Health Surveillance Program
1000 Frederick Lane, M/S LB208
Morgantown, WV 26508

Form Approved
OMB No. 0920-0020

Spirometry Facility Certification Form**Section 1 Facility** Facility Name _____ Telephone number _____ Email _____

Street Address _____ City _____ State _____ Zip Code _____ County _____

Type of Facility (Mobile, Clinic, Private Office, Hospital) _____ How many spirometry tests per year? _____

Section 2 Spirometry System(s) * Items are required**Unit 1**

A. Room number (if applicable) _____

B. Manufacturer * _____

C. Model * _____

D. Serial # _____

E. Date acquired _____

F. Spirometer validation letter (attached)* _____ Yes _____

G. Spirometer automated quality control* _____ Yes _____

H. Calibration check available* _____ Yes _____

I. Graphical Displays

1. Meets 2005 ATS/ERS Standards* Volume-Time Flow-Volume

2. Real-time during testing* Volume-Time Flow-Volume

J. Test report for interpreter (sample attached) Yes

K. Spirometry data file

1. Stores 2005 ATS/ERS parameters* Yes

2. Stores all maneuvers Yes If NO, max # _____

3. Electronic output format* 2005 ATS/ERS NIOSH-approved

Unit 2

_____ Yes

_____ Yes

_____ Yes

Volume-Time Flow-Volume

Volume-Time Flow-Volume

_____ Yes

_____ Yes

Yes If NO, max # _____

2005 ATS/ERS NIOSH-approved

Section 3 Program and Staff Information

L. Spirometry procedure manual (available in lab) Yes: mo/yr revised _____ Yes: mo/yr revised _____

M. Ongoing spirometry quality assurance program Yes: mo/yr revised _____ Yes: mo/yr revised _____

N. Height measurement device Stadiometer (brand) _____ Other _____

O. Weight measurement device Medical scale (brand) _____ Other _____

P. Name(s) of spirometry technologist(s) Copy of NIOSH approved spirometry certificate attached?

_____ Yes _____ Yes

_____ Yes _____ Yes

Q. I agree to participate in this program in the manner specified by Part 37 of the Code of Federal Regulations (42 CFR Part 37), and understand that all information used in connection with this program will be held STRICTLY CONFIDENTIAL and divulged only as specified by the above Regulation.

Supervising Clinician Name (copy of license attached)

Signature

Date

Clinician certification or specialized spirometry training institution

Title+ Date of course or certification

Clinician Email

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-74, Atlanta, GA, 30333, ATTN: PRA (0920-0020).