Attachment 13- Spirometry Facility Certification Document

Form Approved

OMB No. 0920-0020

Expires xx/xx/20xx

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| Spirometry Facility Certification Document  Form Approved OMB No. xxxx-xxxx  CDC/NIOSH 2.?14 REV 06/2014 | NIOSH Coal Workers' Health Surveillance Program 1095 Willowdale Rd.  Morgantown, WV 26505 |

Facility Name Telephone Number

Street Address Email

City State Zip Code County

Type of Facility (Mobile, Clinic, Private Office, Hospital) How many spirometries per year? \_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Spirometry System(s) Used** | Unit #1 | |  | Unit #2 | |
| Room Number (if applicable) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Manufacturer | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Model | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Serial # | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Date acquired | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Spirometer Validation Letter**\*** (attached) | □ Yes | |  | □ Yes | |
| Automated Quality Control**\*** | □ Yes | |  | □ Yes | |
| Calibration Check Available**\*** | □ Yes | |  | □ Yes | |
| Graphical Displays |  |  |  |  |  |
| Meet 2005 ATS/ERS size standards**\*** | □ Volume-Time | □ Flow-Volume |  | □ Volume-Time | □ Flow-Volume |
| Real-time during testing**\*** | □ Volume-Time | □ Flow-Volume |  | □ Volume-Time | □ Flow-Volume |
| Test Report for Interpreter**\*** (sample attached) | □ Yes | |  | □ Yes | |
| Spirometry data file |  | |  |  | |
| Stores 2005 ATS/ERS parameters**\*** | □ Yes | |  | □ Yes | |
| Stores all maneuvers | □ Yes | □ if No, max # \_\_\_ |  | □ Yes | □ if No, max # \_\_\_ |
| Electronic Output Format\* | □ 2005 ATS/ERS | □ NIOSH-approved |  | □ 2005 ATS/ERS | □ NIOSH-approved |
| **\*Items indicated by asterisk are required** | | | | | |
| **Spirometry procedure manual** available in laboratory □ Yes (mo/yr revised\_\_\_\_\_/\_\_\_\_\_\_) □ No | | | | | |
| **Ongoing spirometry quality assurance program** □ Yes (mo/yr revised\_\_\_\_\_/\_\_\_\_\_\_) □ No | | | | | |
| **Height Measurement Device** | □ Stadiometer (brand) \_\_ | |  | □ Other | |
| **Weight Measurement Device** | □ Medical scale (brand) | |  | □ Other | |

Name(s) of Spirometry Technologist(s) Copy of NIOSH-Approved Spirometry Certificate attached

□ Yes

□ Yes

□ Yes

□ Yes

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 (copy of license attached) Signature Date

Clinician certification or specialized spirometry training

Institution Title of course or certification Date completed

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).