

Attachment 13- Spirometry Facility Certification Document

Spirometry Facility Certification Document

Form Approved OMB No. xxxx-xxxx
 CDC/NIOSH 2.714 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) | <input type="checkbox"/> Yes | | <input type="checkbox"/> Yes |
| Automated Quality Control* | <input type="checkbox"/> Yes | | <input type="checkbox"/> Yes |
| Calibration Check Available* | <input type="checkbox"/> Yes | | <input type="checkbox"/> Yes |
| Graphical Displays | | | |
| Meet 2005 ATS/ERS size standards* | <input type="checkbox"/> Volume-Time <input type="checkbox"/> Flow-Volume | | <input type="checkbox"/> Volume-Time <input type="checkbox"/> Flow-Volume |
| Real-time during testing* | <input type="checkbox"/> Volume-Time <input type="checkbox"/> Flow-Volume | | <input type="checkbox"/> Volume-Time <input type="checkbox"/> Flow-Volume |
| Test Report for Interpreter* (sample attached) | <input type="checkbox"/> Yes | | <input type="checkbox"/> Yes |
| Spirometry data file | | | |
| Stores 2005 ATS/ERS parameters* | <input type="checkbox"/> Yes | | <input type="checkbox"/> Yes |
| Stores all maneuvers | <input type="checkbox"/> Yes <input type="checkbox"/> if No, max # _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> if No, max # _____ |
| Electronic Output Format* | <input type="checkbox"/> 2005 ATS/ERS <input type="checkbox"/> NIOSH-approved | | <input type="checkbox"/> 2005 ATS/ERS <input type="checkbox"/> 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).