Report of Ventilatory Study

U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

Note: This report is authorized by law (30 U.S.C. 901 et. seq.) and required to obtain a benefit. The results of this interpretation will aid in determining the miner's eligibility for black lung benefits. Disclosure of a Social Security number is voluntary. The failure to disclose such number will not result in the denial of any right, benefit, or privilege to which the claimant may be entitled. This method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974, and OMB Circular No. 108.

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Instructions: Any ventilatory study must include tracings of flow versus volume (flow-volume loop) as part of the reported test. If the spirometer used for this test cannot provide a flow-volume loop, indicate this fact in item 10. Submit three tracings of the flow-volume loop which displays the entire maximum inspiration and the entire maximum forced expiration, and three tracings of the volume versus time (spirogram) derived electronically from the flow-volume loop. Identify each tracing with the patient's name and social security number/DOL Claim Number. Report the results of the FEV1, the FVC and the FEVI/FVC ratio (expressed as a per centage). If a br onchodilator is administered, report the values obtained both before and af ter bronchodilation and explain the significance of the results obtained in item 10. Measuring and reporting the MVV is optional. If the MVV is measured, submit two tracings of the individual breath volumes versus time if the MVV values obtained are within 10% of each other; otherwise, submit three tracings. The MVV results must be obtained independently, rather than calculated from the FEV1. Complete instructions and standards for administration of these tests may be found in 20 CFR Part 718, Subpart B, 718.103, and Appendix B, and are summarized on Form CM-2954a.

1. Name of Miner (First, middle, last)	2. Social Security number or DOL Claim Number:	3. Date and Time of Test
		___|___|___ MM DD YY ____:____ a.m. ☐ p.m. ☐

4. Age:	5. Sex:	8. Circle as appropriate (If "poor", explain in no. 10. "Additional Comments", the nature and extent of any impact this factor had on the results obtained.)			
6. Height (Inches):	7. Weight:	Miner's Degree of Cooperation:	Good	Fair	Poor
		Miner's ability to understand instructions and follow directions:	Good	Fair	Poor

9. (a) Type of Test	(b) Observed values BEFORE Bronchodilator (Corrected to BTPS) **Be sure to also note your findings in Block D5 of the CM-988, if applicable.**	(c) Observed values AFTER Bronchodilator, if given (Corrected to BTPS) **Be sure to also note your findings in Block D5 of the CM-988, if applicable.**	(d) Predicted Normal Values
FEV1 (In liters/second) (Required)			
FVC (In liters) (Required)			
FEV1/FVC Ratio (Required)			
MVV (In liters / minute) (Optional)			

10. Additional Comments (For example - note any dyspnea, use of bronchodilators, coughing during test: If the miner was unable to complete the test, explain the reason for such failure.):

11. (a) Type of machine used (Trade name) (b) Rate of paper speed (c) Temperature of Equipment

12. Facility where test performed	13. Print or Type Name and Title of Technician or Physician or administering test

I certify that these ventilatory studies were conducted and reported in compliance with specifications and instructions provided by the Department of Labor. I also certify that the information furnished is correct and I am aware that my signature attests to the accuracy of the results reported. I am aware that any person who willfully makes any false or misleading statement or representation in support of an application for benefits shall be guilty under Title 30 USC 941 of a misdemeanor and subject to a fine of up to $1000, or imprisonment for up to one year, or both.

Print or Type Name of Physician	Physician's Signature	Date

Public Burden Statement

We estimate that it will take an average of 10 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and c ompleting and r eviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect to this collection of information, including suggestions for reducing this burden, send them to the Division of Coal Mine Workers' Compensation, U.S. Department of Labor, Room N-3464, 200 Constitution Avenue N. W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM THIS OFFICE**

NOTE: Persons are not required to respond to this collection of information unless it displays a current valid OMB control number.

Privacy Act Statement

The following statement is made in accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a). This report is authorized by law (30 USC 922 section 20 CFR 725.513). The information you furnish on this form may be routinely disclosed without your consent to another person or Government agency for purposes such as (1) to comply with Federal laws requiring the release of information from our records; or (2) to conduct research and audit activities needed to assure the continuing integrity and improvement of the U.S. Department of Labor representative payee program. Other routine disclosures of this information are listed in the Federal Register, which will be made available upon request.

Accommodation Statement

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or your claims examiner to ask about this assistance.