

Attachment 15 –  
Spirometry Facility Certification Document – Form 2.14

**SPIROMETRY FACILITY CERTIFICATION**  
 DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR DISEASE CONTROL AND PREVENTION  
 NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

NIOSH  
 Coal Workers' Health Surveillance Program  
 1095 Willowdale Road, M/S LB208  
 Morgantown, WV 26505  
 FAX: 304-285-6058

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	
NIOSH Facility – Unit Number	_____		_____	
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 treated in a secure manner and will not be disclosed, unless otherwise compelled by law.

Supervising Clinician (attach license copy) \_\_\_\_\_ Email Address \_\_\_\_\_ Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

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)

