

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)

