Attachment 15 –
Spirometry Facility Certification Document – Form 2.14

Form Approved
OMB No 0920-0020
Exp. Date xx/xx/20xx

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)	☐ 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 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 _____