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| 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? \_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
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| **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

|  |  |  |  |
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| 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 Title of course or certification Date Completed spirometry training Institution | | | |
| 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) | | | |
| CDC/NIOSH 2.14 Rev. 01/2015 | | | |