

**Instructions & Sample Test Report:**

Open and print

NIOSH  
Coal Workers' Health Surveillance Program  
1000 Frederick Lane, M/S LB208  
Morgantown, WV 26508

Form Approved  
OMB No. 0920-0020

**Spirometry Facility Certification Form**

**Section 1 Facility** Facility Name \_\_\_\_\_ Telephone number \_\_\_\_\_ Email \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_  
Type of Facility (Mobile, Clinic, Private Office, Hospital) \_\_\_\_\_ How many spirometry tests per year? \_\_\_\_\_

<b>Section 2 Spirometry System(s) * Items are required</b>		<u>Unit 1</u>	<u>Unit 2</u>
A. Room number (if applicable) .....	_____	_____	_____
B. Manufacturer * .....	_____	_____	_____
C. Model * .....	_____	_____	_____
D. Serial # .....	_____	_____	_____
E. Date acquired .....	_____	_____	_____
F. Spirometer validation letter (attached)* .....	Yes .....	_____	Yes
G. Spirometer automated quality control* .....	Yes .....	_____	Yes
H. Calibration check available* .....	Yes .....	_____	Yes
I. Graphical Displays			
1. Meets 2005 ATS/ERS Standards*      Volume-Time      Flow-Volume		_____	Volume-Time      Flow-Volume
2. Real-time during testing*      Volume-Time      Flow-Volume		_____	Volume-Time      Flow-Volume
J. Test report for interpreter (sample attached)	Yes	_____	Yes
K. Spirometry data file			
1. Stores 2005 ATS/ERS parameters*      Yes		_____	Yes
2. Stores all maneuvers      Yes      If NO, max # _____		_____	Yes      If NO, max # _____
3. Electronic output format*      2005 ATS/ERS      NIOSH-approved		_____	2005 ATS/ERS      NIOSH-approved

**Section 3 Program and Staff Information**

L. Spirometry procedure manual (available in lab)      Yes: mo/yr revised \_\_\_\_\_      Yes: mo/yr revised \_\_\_\_\_

M. Ongoing spirometry quality assurance program      Yes: mo/yr revised \_\_\_\_\_      Yes: mo/yr revised \_\_\_\_\_

N. Height measurement device      Stadiometer (brand) \_\_\_\_\_      Other \_\_\_\_\_

O. Weight measurement device      Medical scale (brand) \_\_\_\_\_      Other \_\_\_\_\_

P. Name(s) of spirometry technologist(s)      Copy of NIOSH approved spirometry certificate attached?

\_\_\_\_\_      Yes      \_\_\_\_\_      Yes

\_\_\_\_\_      Yes      \_\_\_\_\_      Yes

Q. 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 held STRICTLY CONFIDENTIAL and divulged only as specified by the above Regulation.

**Supervising Clinician Name (copy of license attached)**      Signature      Date

\_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_

Clinician certification or specialized spirometry training institution      Title+ Date of course or certification      Clinician Email

\_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_

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).