

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? _____

Section 2 Spirometry System(s) * Items are required		<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).