Instructions & Sample Test Report:

Open and print

NIOSH
Coal Workers' Health Surveillance Program
1095 Willowdale Road, M/S LB208
Morgantown, WV 26505

Form Approved
OMB No. 0920-0020

Reset Form

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

	Unit 1	Unit 2
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).

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