

November 10, 1993 Contact: Standards & Technical Resources, 378-3272

DEPARTMENT OF
CONSUMER AND
BUSINESS SERVICES

**OR-OSHA ADOPTS BY REFERENCE
NEW FEDERAL STANDARD ON LEAD FOR CONSTRUCTION**



On May 4, 1993, Federal OSHA adopted an interim final standard on **Lead for the Construction Industry** (29 CFR 1926.62) in order to protect more than 900,000 construction workers nationwide against the hazards of exposure to lead. OR-OSHA had previously applied the General Industry Lead standard across the board to ALL industries. This new federal interim final standard specifically applies to Construction.

OR-OSHA has adopted this standard into Division 3, Construction, **EFFECTIVE 11/1/93.** By now adopting the new Construction Lead Standard by reference into OAR 437, Division 3, Construction, it becomes absolutely clear that construction workers are also covered by this standard.

This new standard's purpose is to reduce the incidence of acute lead poisoning, and the adverse neurological and biochemical effects of it. Also, long-term benefits will include reduced cases of lead-induced hypertension, heart attacks, strokes, renal disease and reproductive disorders.

The following is an overview of those parts of the standard that are changed from the General Industry requirements:

- Initial determination/exposure assessment - Employer must make an initial assessment to determine if any employees exposed above the action level. In construction standard, there are requirements for employee protection during the assessment for specific tasks. For these tasks, employees must be protected as if exposed above the PEL.
- General industry contingent on 30 days of exposure for engineering and work practice controls whereas construction not tied to 30 days of exposure.
- Compliance program in writing prior to start of each job, including frequent and regular jobsite inspections.
- Description of arrangements with contractors.

(List continued on page 2)

For more information, contact Sharon Dey or Mike Fajer, Standards & Technical Resources, at (503) 378-3272.

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- Evaluation of effectiveness of mechanical ventilation.
- Employer must ensure employees following good work practices.
- Initial medical surveillance to employees exposed on any day.
- Biological monitoring every two months for first six months and notify each employee in writing of blood lead level.
- Initial training prior to job assignment also on hazards to fetus.
- Maintain record of objective data.

NOTE 1: Copies of the standard adopted by reference are **available upon request** by calling (503) 378-3272 (or toll free 1-800-922-2689 to leave message); or by written request to OR-OSHA, Department of Consumer & Business Services, Labor & Industries Building, Salem, OR 97310. To pick up a copy, the street address of the Labor & Industries Building is 350 Winter St NE, Salem.

NOTE 2: In compliance with the Americans with Disabilities Act (ADA), this publication is available in alternate formats by calling Jan Wagner at (503) 378-3272.

OR-OSHA Admin. Order 16-1993

CERTIFICATE AND ORDER
FOR FILING
PERMANENT
ADMINISTRATIVE RULES WITH THE SECRETARY OF STATE

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SEC. OF STATE

I HEREBY CERTIFY that the attached copy is a true, full and correct copy of PERMANENT rule(s) adopted on November 1, 1993
(Date)

by the DEPARTMENT OF CONSUMER & BUSINESS SERVICES, OREGON OCCUPATIONAL SAFETY & HEALTH DIVISION
(Department) (Division) (OR-OSHA)

to become effective November 1, 1993
(Date)

The within matter having come before the Department of Consumer & Business Services, Oregon OSHA after
(Department) (Division)

all procedures having been in the required form and conducted in accordance with applicable statutes and rules and being fully advised in the premises:

Notice of Intended Action published in Secretary of State's Bulletin: NO YES Date Published: October 1, 1993

NOW THEREFORE, IT IS HEREBY ORDERED THAT the following action be taken: (List Rule Number(s) or Rule Title(s) on Appropriate Lines Below)

Amended: OAR 437, Div. 3, CONSTRUCTION, Subdiv. D, Occupational Health & Environmental Controls, OAR 437-03-001, and 29 CFR 1926.62, LEAD (federal standard adopted by reference).

as Administrative Rules of the Department of Consumer & Business Services, Oregon OSHA
(Department) (Division)

DATED this 1st day of November 1993

By: [Signature]
(Authorized Signer)

Title: Deputy Director

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RECEIVED
Legislative Counsel's
Office

Statutory Authority: ORS 654.025(2) and 656.726(3)

Subject Matter: On 5/4/93, Federal OSHA adopted an interim final standard on LEAD for the Construction Industry (29 CFR 1926.62) in order to protect more than 900,000 construction workers nationwide against the hazards of exposure to lead. This interim standard makes the permissible exposure limit (PEL) for lead in Construction the same as currently in effect for General Industry, which is 50 micrograms of lead per cubic meter.

This new standard's purpose is to reduce the incidence of acute lead poisoning and the adverse neurological and biochemical effects of it. Also, long-term benefits will include reduced cases of lead-induced hypertension, heart attacks, strokes, renal disease and reproductive disorders.

Unlike Federal OSHA, OR-OSHA currently applies the General Industry Lead standard to the Construction Industry. By adopting the new Construction Lead standard by reference, it becomes absolutely clear that construction workers are also covered by this standard.

EXHIBIT "A"

NOTE: On 5/4/93, Federal OSHA adopted an interim final standard on **Lead for the Construction Industry** (29 CFR 1926.62). Oregon OSHA now adopted by reference this new federal standard, by OR-OSHA Admin. Order 16-1993, filed 11/1/93, **EFFECTIVE 11/1/93.**

Oregon-initiated Rule 437-03-001 is the rule which adopts by reference the new federal standard (see 437-03-001(4)(l)).

(The new Lead standard for Construction was published in the Federal Register on 5/4/93, vol. 58, no. 84, pp. 26627-26649.)

**OAR 437, DIVISION 3
CONSTRUCTION**

437-03-001 Adoption by Reference. In addition to, and not in lieu of, any other safety and health codes contained in OAR Chapter 437, the Department adopts by reference the following federal rules as printed in the Code of Federal Regulations, 29 CFR 1926, revised as of 7/1/92:

(1) Subdivision A - GENERAL

- (a) 29 CFR 1926.1 **Purpose and Scope**, published 2/9/79, Federal Register (FR), vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.
- (b) 29 CFR 1926.2 **Variances from safety and health standards**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.
- (c) 29 CFR 1926.3 **Inspections - right of entry**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.
- (d) 29 CFR 1926.4 **Rules of practice for administrative adjudications for enforcement of safety and health standards**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(2) Subdivision B - GENERAL INTERPRETATIONS

- (a) 29 CFR 1926.10 **Scope of subpart**, published 2/9/79, Federal Register, vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.
- (b) 29 CFR 1926.11 **Coverage under section 103 of the act distinguished**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.
- (c) 29 CFR 1926.12 **Reorganization plan No. 14 of 1950**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.
- (d) 29 CFR 1926.13 **Interpretation of statutory terms**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.
- (e) 29 CFR 1926.14 **Federal contracts for 'mixed' types of performance**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.
- (f) 29 CFR 1926.15 **Relationship to the service contract act; Walsh-Healey Public Contracts Act**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

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(g) 29 CFR 1926.16 **Rules of construction**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(3) Subdivision C - GENERAL SAFETY AND HEALTH PROVISIONS

(a) 29 CFR 1926.20 **General safety and health provisions**, published 2/9/79, Federal Register, vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(b) 29 CFR 1926.21 **Safety training and education**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(c) 29 CFR 1926.22 **Recording and reporting of injuries** (Reserved)

(d) 29 CFR 1926.23 **First aid and medical attention**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(e) 29 CFR 1926.24 **Fire protection and prevention**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(f) 29 CFR 1926.25 **Housekeeping**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(g) 29 CFR 1926.26 **Illumination**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(h) 29 CFR 1926.27 **Sanitation**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(i) 29 CFR 1926.28 **Personal protective equipment**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(j) 29 CFR 1926.29 **Acceptable certifications**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(k) 29 CFR 1926.30 **Shipbuilding and ship repairing**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(l) 29 CFR 1926.31 **Incorporation by reference**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(m) 29 CFR 1926.32 **Definitions**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(4) Subdivision D - OCCUPATIONAL HEALTH AND ENVIRONMENTAL CONTROLS

(a) 29 CFR 1926.50 **Medical services and first aid**, published 2/9/79, Federal Register, vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(b) 29 CFR 1926.51 **Sanitation**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(c) 29 CFR 1926.52 **Occupational noise exposure**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(d) 29 CFR 1926.53 **Ionizing radiation**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(e) 29 CFR 1926.54 **Nonionizing radiation**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(f) 29 CFR 1926.55 **Gases, vapors, fumes, dusts, and mists**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940; 10/17/86, FR vol. 51, p. 37007; 12/4/87, FR vol. 52, p. 46312.

(g) 29 CFR 1926.56 **Illumination**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(h) 29 CFR 1926.57 **Ventilation**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940.

(i) 29 CFR 1926.58 **Asbestos**, published 2/9/79, FR vol. 44, p. 8577; amended 4/6/79, FR vol. 44, p. 20940; 6/20/86, FR vol. 51, p. 22612; 10/17/86, FR vol. 51, p. 37002; 4/30/87, FR vol. 52, p. 15723; 5/12/87, FR vol. 52, p. 17756; 7/20/88, FR vol. 53, no. 139, p. 27346; 9/14/88, FR vol. 53, p. 35627; 9/23/88, FR vol. 53, no. 185, p. 37080; 7/21/89, FR vol. 54, no. 139, p. 30705; 12/20/89, FR vol. 54, no. 243, pp. 52027-52028; 2/5/90, FR vol. 55, no. 24, p. 3792; 12/10/90, FR vol. 55, no. 237, pp. 50685-50687; 9/4/91, FR vol. 56, no. 171, pp. 43699-43700; 3/5/92, FR vol. 57, no. 44, p. 7878; 6/8/92, FR vol. 57, no. 110, pp. 24330-1; 6/30/92, FR vol. 57, no. 126, p. 29119.

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- (j) 29 CFR 1926.59 **Hazard Communication**, published 8/24/87, FR vol. 52, p. 31852; amended 12/4/87, FR vol. 52, 46075; 4/27/88, FR vol. 53, no. 81, pp. 15033-15035; stay lifted on 2/17/89, FR vol. 54, p. 6886.
- (k) 29 CFR 1926.60 **Methylenedianiline (MDA)**, published 8/10/92, FR vol. 57, no. 154, pp. 35681-35695.
- (l) 29 CFR 1926.62 **Lead**, published 5/4/93, FR vol. 58, no. 84, pp. 26626-26649.
- [(l)] (m) 29 CFR 1926.63 **Cadmium**, published 9/14/92, FR vol. 57, no. 178, pp. 42453-42463, amended 4/23/93, FR vol. 58, no. 77, p. 21778.

Stat. Auth.: ORS 654.025(2) and ORS 656.726(3).

Hist : APD Admin. Order 5-1989, f. 3/31/89, ef. 5/1/89 (temp).
APD Admin. Order 8-1989, f. 7/7/89, ef. 7/7/89 (perm).
APD Admin. Order 14-1989, f. 7/20/89, ef. 8/1/89 (temp).
APD Admin. Order 15-1989, f. 9/13/89, ef. 9/13/89 (perm).
OR-OSHA Admin. Order 3-1990, f. 1/19/90, ef. 1/19/90 (temp).
OR-OSHA Admin. Order 7-1990, f. 3/2/90, ef. 3/2/90 (perm).
OR-OSHA Admin. Order 8-1990, f. 3/30/90, ef. 3/30/90.
OR-OSHA Admin. Order 13-1990, f. 6/28/90, ef. 8/1/90 (temp).
OR-OSHA Admin. Order 19-1990, f. 8/31/90, ef. 8/31/90 (perm).
OR-OSHA Admin. Order 27-1990, f. 12/12/90, ef. 2/1/91.
OR-OSHA Admin. Order 6-1991, f. 3/18/91, ef. 4/15/91.
OR-OSHA Admin. Order 7-1991, f. 4/25/91, ef. 4/25/91.
OR-OSHA Admin. Order 15-1991, f. 12/13/91, ef. 12/13/91.
OR-OSHA Admin. Order 6-1992, f. 5/18/92, ef. 5/18/92.
OR-OSHA Admin. Order 11-1992, f. 10/9/92, ef. 10/9/92.
OR-OSHA Admin. Order 1-1993, f. 1/22/93, ef. 1/22/93.
OR-OSHA Admin. Order 16-1993, f. 11/1/93, ef. 11/1/93 (Lead).

NOTE: 437-03-001(5) through (24) which list Federal Register citations for Subdivisons 3/E through 3/X, are not printed here because they are not changed or affected by this adoption.

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EXHIBIT "A" Continued

NOTE: The following new federal standard for **Lead in Construction** has been adopted by reference into Div. 3/D, Occupational Health and Environmental Controls.

Authority: Sec. 107, Contract Work Hours and Safety Standards Act (Construction Safety Act) (40 U.S.C. 333); secs. 4, 6, 8, Occupational Safety and Health Act of 1970 (29 U.S.C. 653, 655, 657); Secretary of Labor's Order No. 12-71 (36 FR 8754), 8-76 (41 FR 25059), or 9-83 (48 FR 35736), as applicable.

Section 1926.59 also issued under 5 U.S.C. 553 and 29 CFR Part 1911.

Section 1926.62 issued under sec. 1031 of the Housing and Community Development Act of 1992 (sec. 1031, title X, 106 Stat. 3924 (42 U.S.C. 4853)).

§1926.62 LEAD.

(a) Scope. This section applies to all construction work where an employee may be occupationally exposed to lead. All construction work excluded from coverage in the general industry standard for lead by 29 CFR 1910.1025(a)(2) is covered by this standard. Construction work is defined as work for construction, alteration and/or repair, including painting and decorating. It includes but is not limited to the following:

- (1) Demolition or salvage of structures where lead or materials containing lead are present;
- (2) Removal or encapsulation of materials containing lead;
- (3) New construction, alteration, repair, or renovation of structures, substrates, or portions thereof, that contain lead, or materials containing lead;
- (4) Installation of products containing lead;
- (5) Lead contamination/emergency cleanup;
- (6) Transportation, disposal, storage, or containment of lead or materials containing lead on the site or location at which construction activities are performed, and
- (7) Maintenance operations associated with the construction activities described in this paragraph.

(b) Definitions.

Action level means employee exposure, without regard to the use of respirators, to an airborne concentration of lead of 30 micrograms per cubic meter of air (30 $\mu\text{g}/\text{m}^3$) calculated as an 8-hour time-weighted average (TWA).

Assistant Secretary means the Assistant Secretary of Labor for Occupational Safety and Health, U.S. Department of Labor, or designee.

Competent person means one who is capable of identifying existing and predictable lead hazards in the surroundings or working conditions and who has authorization to take prompt corrective measures to eliminate them.

Director means the Director, National Institute for Occupational Safety and Health (NIOSH), U.S. Department of Health and Human Services, or designee.

Lead means metallic lead, all inorganic lead compounds, and organic lead soaps. Excluded from this definition are all other organic lead compounds.

This section means this standard.

(c) Permissible exposure limit.

(1) The employer shall assure that no employee is exposed to lead at concentrations greater than fifty micrograms per cubic meter of air (50 $\mu\text{g}/\text{m}^3$) averaged over an 8-hour period.

(2) If an employee is exposed to lead for more than 8 hours in any work day the employees' allowable exposure, as a time weighted average (TWA) for that day, shall be reduced according to the following formula:

Allowable employee exposure (in $\mu\text{g}/\text{m}^3$) = 400
divided by hours worked in the day.

(3) When respirators are used to limit employee exposure as required under paragraph (c) of this section and all the requirements of paragraphs (e)(1) and (f) of this section have been met, employee exposure may be considered to be at the level provided by the protection factor of the respirator for those periods the respirator is worn. Those periods may be averaged with exposure levels during periods when respirators are not worn to determine the employee's daily TWA exposure.

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(d) Exposure assessment.

(1) General.

(i) Each employer who has a workplace or operation covered by this standard shall initially determine if any employee may be exposed to lead at or above the action level.

(ii) For the purposes of paragraph (d) of this section, employee exposure is that exposure which would occur if the employee were not using a respirator.

(iii) With the exception of monitoring under paragraph (d)(3), where monitoring is required under this section, the employer shall collect personal samples representative of a full shift including at least one sample for each job classification in each work area either for each shift or for the shift with the highest exposure level.

(iv) Full shift personal samples shall be representative of the monitored employee's regular, daily exposure to lead.

(2) Protection of employees during assessment of exposure.

(i) With respect to the lead related tasks listed in paragraph (d)(2)(i) of this section, where lead is present, until the employer performs an employee exposure assessment as required in paragraph (d) of this section and documents that the employee performing any of the listed tasks is not exposed above the PEL, the employer shall treat the employee as if the employee were exposed above the PEL, and not in excess of ten (10) times the PEL, and shall implement employee protective measures prescribed in paragraph (d)(2)(v) of this section. The tasks covered by this requirement are:

(A) Where lead containing coatings or paint are present: Manual demolition of structures (e.g, dry wall), manual scraping, manual sanding, heat gun applications, and power tool cleaning with dust collection systems;

(B) Spray painting with lead paint.

(ii) In addition, with regard to tasks not listed in paragraph (d)(2)(i), where the employee has any reason to believe that an employee performing the task may be exposed to lead in excess of the PEL, until the employer performs an employee exposure assessment as required by paragraph (d) of this section and documents

that the employee's lead exposure is not above the PEL the employer shall treat the employee as if the employee were exposed above the PEL and shall implement employee protective measures as prescribed in paragraph (d)(2)(v) of this section.

(iii) With respect to the tasks listed in paragraph (d)(2)(iii) of this section, where lead is present, until the employer performs an employee exposure assessment as required in paragraph (d) of this section, and documents that the employee performing any of the listed tasks is not exposed in excess of 500 $\mu\text{g}/\text{m}^3$, the employer shall treat the employee as if the employee were exposed to lead in excess of 500 $\mu\text{g}/\text{m}^3$ and shall implement employee protective measures as prescribed in paragraph (d)(2)(v) of this section. Where the employer does establish that the employee is exposed to levels of lead below 500 $\mu\text{g}/\text{m}^3$, the employer may provide the exposed employee with the appropriate respirator prescribed for such use at such lower exposures, in accordance with Table 1 of this section. The tasks covered by this requirement are:

(A) Using lead containing mortar; lead burning

(B) Where lead containing coatings or paint are present: rivet busting; power tool cleaning without dust collection systems; cleanup activities where dry expendable abrasives are used; and abrasive blasting enclosure movement and removal.

(iv) With respect to the tasks listed in paragraph (d)(2)(iv) of this section, where lead is present, until the employer performs an employee exposure assessment as required in paragraph (d) of this section and documents that the employee performing any of the listed tasks is not exposed to lead in excess of 2,500 $\mu\text{g}/\text{m}^3$ (50 x PEL), the employer shall treat the employee as if the employee were exposed to lead in excess of 2,500 $\mu\text{g}/\text{m}^3$ and shall implement employee protective measures as prescribed in paragraph (d)(2)(v) of this section. Where the employer does establish that the employee is exposed to levels of lead below 2,500 $\mu\text{g}/\text{m}^3$, the employer may provide the exposed employee with the appropriate respirator prescribed for use at such lower exposures, in accordance with Table 1 of this section. Interim protection as described in this paragraph is required where lead containing coatings or paint are present on structures when performing:

(A) Abrasive blasting,

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- (B) Welding,
- (C) Cutting, and
- (D) Torch burning.

(v) Until the employer performs an employee exposure assessment as required under paragraph (d) of this section and determines actual employee exposure, the employer shall provide to employees performing the tasks described in paragraphs (d)(2)(i), (d)(2)(ii), (d)(2)(iii), and (d)(2)(iv) of this section with interim protection as follows:

- (A) Appropriate respiratory protection in accordance with paragraph (f) of this section.
- (B) Appropriate personal protective clothing and equipment in accordance with paragraph (g) of this section.
- (C) Change areas in accordance with paragraph (i)(2) of this section.
- (D) Hand washing facilities in accordance with paragraph (i)(5) of this section.
- (E) Biological monitoring in accordance with paragraph (j)(1)(i) of this section, to consist of blood sampling and analysis for lead and zinc protoporphyrin levels, and
- (F) Training as required under paragraph (l)(1)(i) of this section regarding 29 CFR 1926.59, Hazard Communication; training as required under paragraph (l)(2)(ii)(C) of this section, regarding use of respirators; and training in accordance with 29 CFR 1926.21, Safety training and education.

(3) Basis of initial determination.

(i) Except as provided under paragraphs (d)(3)(iii) and (d)(3)(iv) of this section the employer shall monitor employee exposures and shall base initial determinations on the employee exposure monitoring results and any of the following, relevant considerations:

- (A) Any information, observations, or calculations which would indicate employee exposure to lead;
- (B) Any previous measurements of airborne lead; and
- (C) Any employee complaints of symptoms which may be attributable to exposure to lead.

(ii) Monitoring for the initial determination where performed may be limited to a representative sample of the exposed employees who the

employer reasonably believes are exposed to the greatest airborne concentrations of lead in the workplace.

(iii) Where the employer has previously monitored for lead exposures, and the data were obtained within the past 12 months during work operations conducted under workplace conditions closely resembling the processes, type of material, control methods, work practices, and environmental conditions used and prevailing in the employer's current operations, the employer may rely on such earlier monitoring results to satisfy the requirements of paragraphs (d)(3)(i) and (d)(6) of this section if the sampling and analytical methods meet the accuracy and confidence levels of paragraph (d)(10) of this section.

(iv) Where the employer has objective data, demonstrating that a particular product or material containing lead or a specific process, operation or activity involving lead cannot result in employee exposure to lead at or above the action level during processing, use, or handling, the employer may rely upon such data instead of implementing initial monitoring.

(A) The employer shall establish and maintain an accurate record documenting the nature and relevancy of objective data as specified in paragraph (n)(4) of this section, where used in assessing employee exposure in lieu of exposure monitoring.

(B) Objective data, as described in paragraph (d)(3)(iv) of this section, is not permitted to be used for exposure assessment in connection with paragraph (d)(2) of this section.

(4) Positive initial determination and initial monitoring.

(i) Where a determination conducted under paragraphs (d)(1), (2) and (3) of this section shows the possibility of any employee exposure at or above the action level the employer shall conduct monitoring which is representative of the exposure for each employee in the workplace who is exposed to lead.

(ii) Where the employer has previously monitored for lead exposure, and the data were obtained within the past 12 months during work operations conducted under workplace conditions closely resembling the processes, type of material, control methods, work practices, and environmental conditions used and prevailing in the employer's current operations, the employer may rely on such earlier monitoring results to satisfy the requirements of paragraph (d)(4)(i) of this section if the sampling and analytical methods

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meet the accuracy and confidence levels of paragraph (d)(10) of this section.

(5) Negative initial determination. Where a determination, conducted under paragraphs (d)(1), (2), and (3) of this section is made that no employee is exposed to airborne concentrations of lead at or above the action level the employer shall make a written record of such determination. The record shall include at least the information specified in paragraph (d)(3)(i) of this section and shall also include the date of determination, location within the worksite, and the name and social security number of each employee monitored.

(6) Frequency.

(i) If the initial determination reveals employee exposure to be below the action level further exposure determination need not be repeated except as otherwise provided in paragraph (d)(7) of this section.

(ii) If the initial determination or subsequent determination reveals employee exposure to be at or above the action level but at or below the PEL the employer shall perform monitoring in accordance with this paragraph at least every 6 months. The employer shall continue monitoring at the required frequency until at least two consecutive measurements, taken at least 7 days apart, are below the action level at which time the employer may discontinue monitoring for that employee except as otherwise provided in paragraph (d)(7) of this section.

(iii) If the initial determination reveals that employee exposure is above the PEL the employer shall perform monitoring quarterly. The employer shall continue monitoring at the required frequency until at least two consecutive measurements, taken at least 7 days apart, are at or below the PEL but at or above the action level at which time the employer shall repeat monitoring for that employee at the frequency specified in paragraph (d)(6)(ii) of this section, except as otherwise provided in paragraph (d)(7) of this section. The employer shall continue monitoring at the required frequency until at least two consecutive measurements, taken at least 7 days apart, are below the action level at which time the employer may discontinue monitoring for that employee except as otherwise provided in paragraph (d)(7) of this section.

(7) Additional exposure assessments. Whenever there has been a change of equipment, process, control, personnel or a new task has been initiated that may result in additional employees being

exposed to lead at or above the action level or may result in employees already exposed at or above the action level being exposed above the PEL, the employer shall conduct additional monitoring in accordance with this paragraph.

(8) Employee notification.

(i) Within 5 working days after completion of the exposure assessment the employer shall notify each employee in writing of the results which represent that employee's exposure.

(ii) Whenever the results indicate that the representative employee exposure, without regard to respirators, is at or above the PEL the employer shall include in the written notice a statement that the employees exposure was at or above that level and a description of the corrective action taken or to be taken to reduce exposure to below that level.

(9) Accuracy of measurement. The employer shall use a method of monitoring and analysis which has an accuracy (to a confidence level of 95%) of not less than plus or minus 25 percent for airborne concentrations of lead equal to or greater than $30 \mu\text{g}/\text{m}^3$.

(e) Methods of compliance.

(1) Engineering and work practice controls. The employer shall implement engineering and work practice controls, including administrative controls, to reduce and maintain employee exposure to lead to or below the permissible exposure limit to the extent that such controls are feasible. Wherever all feasible engineering and work practices controls that can be instituted are not sufficient to reduce employee exposure to or below the permissible exposure limit prescribed in paragraph (c) of this section, the employer shall nonetheless use them to reduce employee exposure to the lowest feasible level and shall supplement them by the use of respiratory protection that complies with the requirements of paragraph (f) of this section.

(2) Compliance program.

(i) Prior to commencement of the job each employer shall establish and implement a written compliance program to achieve compliance with paragraph (c) of this section.

(ii) Written plans for these compliance programs shall include at least the following:

(A) A description of each activity in which lead is emitted; e.g., equipment used, material involved, controls in place, crew size, employee job responsibilities, operating procedures and maintenance practices;

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(B) A description of the specific means that will be employed to achieve compliance and, where engineering controls are required engineering plans and studies used to determine methods selected for controlling exposure to lead;

(C) A report of the technology considered in meeting the PEL;

(D) Air monitoring data which documents the source of lead emissions;

(E) A detailed schedule for implementation of the program, including documentation such as copies of purchase orders for equipment, construction contracts, etc.;

(F) A work practice program which includes items required under paragraphs (g), (h) and (i) of this section and incorporates other relevant work practices such as those specified in paragraph (e)(5) of this section;

(G) An administrative control schedule required by paragraph (e)(4) of this section, if applicable;

(H) A description of arrangements made among contractors on multi-contractor sites with respect to informing affected employees of potential exposure to lead and with respect to responsibility for compliance with this section as set-forth in Sec. 1926.16.

(I) Other relevant information.

(iii) The compliance program shall provide for frequent and regular inspections of job sites, materials, and equipment to be made by a competent person.

(iv) Written programs shall be submitted upon request to any affected employee or authorized employee representatives, to the Assistant Secretary and the Director, and shall be available at the worksite for examination and copying by the Assistant Secretary and the Director.

(v) Written programs shall be revised and updated at least every 6 months to reflect the current status of the program.

(3) Mechanical ventilation. When ventilation is used to control lead exposure, the employer shall evaluate the mechanical performance of the system in controlling exposure as necessary to maintain its effectiveness.

(4) Administrative controls. If administrative controls are used as a means of reducing employees TWA exposure to lead, the employer

shall establish and implement a job rotation schedule which includes:

(i) Name or identification number of each affected employee;

(ii) Duration and exposure levels at each job or work station where each affected employee is located; and

(iii) Any other information which may be useful in assessing the reliability of administrative controls to reduce exposure to lead.

(5) The employer shall ensure that, to the extent relevant, employees follow good work practices such as described in Appendix B of this section.

(f) Respiratory protection.

(1) General. Where the use of respirators is required under this section the employer shall provide, at no cost to the employee, and assure the use of respirators which comply with the requirements of this paragraph. Respirators shall be used in the following circumstances:

(i) Whenever an employee's exposure to lead exceeds the PEL;

(ii) In work situations in which engineering controls and work practices are not sufficient to reduce exposures to or below the PEL;

(iii) Whenever an employee requests a respirator; and

(iv) An interim protection for employees performing tasks as specified in paragraph (d)(2) of this section.

(2) Respirator selection.

(i) Where respirators are used under this section the employer shall select the appropriate respirator or combination of respirators from Table I below.

(ii) The employer shall provide a powered, air-purifying respirator in lieu of the respirator specified in Table I whenever:

(A) An employee chooses to use this type of respirator; and

(B) This respirator will provide adequate protection to the employee.

(iii) The employer shall select respirators from among those approved for protection against lead dust, fume, and mist by the Mine Safety and Health Administration and the National Institute for Occupational Safety and Health (NIOSH) under the provisions of 30 CFR part 11.

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**Table I. -- Respiratory Protection
for Lead Aerosols**

**Table I. -- Respiratory Protection
for Lead Aerosols (Continued)**

Airborne concentration of lead or condition of use	Required respirator ^{1/}
Not in excess of 500 µg/m ³	<ul style="list-style-type: none"> • 1/2 mask air purifying respirator with high efficiency filters. ^{2,3/} • 1/2 mask supplied air respirator operated in demand (negative pressure) mode.
Not in excess of 1,250 µg/m ³	<ul style="list-style-type: none"> • Loose fitting hood or helmet powered air purifying respirator with high efficiency filters. ^{3/} • Hood or helmet supplied air respirator operated in a continuous-flow mode--e.g., type CE abrasive blasting respirators operated in a continuous-flow mode.
Not in excess of 2,500 µg/m ³	<ul style="list-style-type: none"> • Full facepiece air purifying respirator with high efficiency filters. ^{3/} • Tight fitting powered air purifying respirator with high efficiency filters. ^{3/} • Full facepiece supplied air respirator operated in demand mode. • 1/2 mask or full facepiece supplied air respirator operated in a continuous-flow mode. • Full facepiece self-contained breathing apparatus (SCBA) operated in demand mode.
Not in excess of 50,000 µg/m ³	<ul style="list-style-type: none"> • 1/2 mask supplied air respirator operated in pressure demand or other positive-pressure mode.

Airborne concentration of lead or condition of use	Required respirator ^{1/}
Not in excess of 100,000 µg/m ³	<ul style="list-style-type: none"> • Full facepiece supplied air respirator operated in pressure demand or other positive-pressure mode--e.g., type CE abrasive blasting respirators operated in a positive-pressure mode.
Greater than 100,000 µg/m ³ unknown concentration, or fire fighting.	<ul style="list-style-type: none"> • Full facepiece SCBA operated in pressure demand or other positive-fighting pressure mode.

^{1/} Respirators specified for higher concentrations can be used at lower concentrations of lead.

^{2/} Full facepiece is required if the lead aerosols cause eye or skin irritation at the use concentrations.

^{3/} A high efficiency particulate filter (HEPA) means a filter that is 99.97 percent efficient against particles of 0.3 micron size or larger.

(3) Respirator usage.

(i) The employer shall assure that the respirator issued to the employee exhibits minimum facepiece leakage and that the respirator is fitted properly.

(ii) Employers shall perform either quantitative or qualitative face fit tests at the time of initial fitting and at least every six months thereafter for each employee wearing negative pressure respirators. The qualitative fit tests may be used only for testing the fit of half-mask respirators where they are permitted to be worn, and shall be conducted in accordance with appendix D of this section. The tests shall be used to select facepieces that provide the required protection as prescribed in Table I.

(iii) If an employee exhibits difficulty in breathing during the fitting test or during use, the employer shall make available to the employee an examination in accordance with paragraph (j)(3)(i)(B) of this section to determine whether the employee can wear a respirator while performing the required duty.

(4) Respirator program.

(i) The employer shall institute a respiratory protection program in accordance with 29 CFR 1910.134(b), (d), (e) and (f).

(ii) The employer shall permit each employee who uses a filter respirator to change the filter elements whenever an increase in breathing resistance is detected and shall maintain an adequate supply of filter elements for this purpose.

(iii) Employees who wear respirators shall be permitted to leave work areas to wash their face and respirator facepiece whenever necessary to prevent skin irritation associated with respirator use.

(g) Protective work clothing and equipment.

(1) **Provision and use.** Where an employee is exposed to lead above the PEL without regard to the use of respirators, where employees are exposed to lead compounds which may cause skin or eye irritation (e.g., lead arsenate, lead azide), and as interim protection for employees performing tasks as specified in paragraph (d)(2) of this section, the employer shall provide at no cost to the employee and assure that the employee uses appropriate protective work clothing and equipment that prevents contamination of the employee and the employee's garments such as, but not limited to:

- (i) Coveralls or similar full-body work clothing;
- (ii) Gloves, hats, and shoes or disposable shoe coverlets; and
- (iii) Face shields, vented goggles, or other appropriate protective equipment which complies with Sec. 1910.133 of this chapter.

(2) Cleaning and replacement.

(i) The employer shall provide the protective clothing required in paragraph (g)(1) of this section in a clean and dry condition at least weekly, and daily to employees whose exposure levels without regard to a respirator are over 200 µg/m³ of lead as an 8-hour TWA.

(ii) The employer shall provide for the cleaning, laundering, and disposal of protective clothing and equipment required by paragraph (g)(1) of this section.

(iii) The employer shall repair or replace required protective clothing and equipment as needed to maintain their effectiveness.

(iv) The employer shall assure that all protective clothing is removed at the completion of a work shift only in change areas provided for that purpose as prescribed in paragraph (i)(2) of this section.

(v) The employer shall assure that contaminated protective clothing which is to be cleaned, laundered, or disposed of, is placed in a closed container in the change area which prevents dispersion of lead outside the container.

(vi) The employer shall inform in writing any person who cleans or launders protective clothing or equipment of the potentially harmful effects of exposure to lead.

(vii) The employer shall assure that the containers of contaminated protective clothing and equipment required by paragraph (g)(2)(v) of this section are labelled as follows:

Caution: Clothing contaminated with lead. Do not remove dust by blowing or shaking. Dispose of lead contaminated wash water in accordance with applicable local, state, or federal regulations.

(viii) The employer shall prohibit the removal of lead from protective clothing or equipment by blowing, shaking, or any other means which disperses lead into the air.

(h) Housekeeping.

(1) All surfaces shall be maintained as free as practicable of accumulations of lead.

(2) Clean-up of floors and other surfaces where lead accumulates shall wherever possible, be cleaned by vacuuming or other methods that minimize the likelihood of lead becoming airborne.

(3) Shoveling, dry or wet sweeping, and brushing may be used only where vacuuming or other equally effective methods have been tried and found not to be effective.

(4) Where vacuuming methods are selected, the vacuums shall be equipped with HEPA filters and used and emptied in a manner which minimizes the reentry of lead into the workplace.

(5) Compressed air shall not be used to remove lead from any surface unless the compressed air is used in conjunction with a ventilation system designed to capture the airborne dust created by the compressed air.

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(i) Hygiene facilities and practices.

(1) The employer shall assure that in areas where employees are exposed to lead above the PEL without regard to the use of respirators, food or beverage is not present or consumed, tobacco products are not present or used, and cosmetics are not applied.

(2) Change areas.

(i) The employer shall provide clean change areas for employees whose airborne exposure to lead is above the PEL, and as interim protection for employees performing tasks as specified in paragraph (d)(2) of this section, without regard to the use of respirators.

(ii) The employer shall assure that change areas are equipped with separate storage facilities for protective work clothing and equipment and for street clothes which prevent cross-contamination.

(iii) The employer shall assure that employees do not leave the workplace wearing any protective clothing or equipment that is required to be worn during the work shift.

(3) Showers.

(i) The employer shall provide shower facilities, where feasible, for use by employees whose airborne exposure to lead is above the PEL.

(ii) The employer shall assure, where shower facilities are available, that employees shower at the end of the work shift and shall provide an adequate supply of cleansing agents and towels for use by affected employees.

(4) Eating facilities.

(i) The employer shall provide lunchroom facilities or eating areas for employees whose airborne exposure to lead is above the PEL, without regard to the use of respirators.

(ii) The employer shall assure that lunchroom facilities or eating areas are as free as practicable from lead contamination and are readily accessible to employees.

(iii) The employer shall assure that employees whose airborne exposure to lead is above the PEL, without regard to the use of a respirator, wash their hands and face prior to eating, drinking, smoking or applying cosmetics.

(iv) The employer shall assure that employees do not enter lunchroom facilities or eating areas with protective work clothing or equipment

unless surface lead dust has been removed by vacuuming, downdraft booth, or other cleaning method that limits dispersion of lead dust.

(5) Hand washing facilities.

(i) The employer shall provide adequate handwashing facilities for use by employees exposed to lead in accordance with 29 CFR 1926.51(f).

(ii) Where showers are not provided the employer shall assure that employees wash their hands and face at the end of the work-shift.

(j) Medical surveillance.

(1) General.

(i) The employer shall make available initial medical surveillance to employees occupationally exposed on any day to lead at or above the action level. Initial medical surveillance consists of biological monitoring in the form of blood sampling and analysis for lead and zinc protoporphyrin levels.

(ii) The employer shall institute a medical surveillance program in accordance with paragraphs (j)(2) and (j)(3) of this section for all employees who are or may be exposed by the employer at or above the action level for more than 30 days in any consecutive 12 months;

(iii) The employer shall assure that all medical examinations and procedures are performed by or under the supervision of a licensed physician.

(iv) The employer shall make available the required medical surveillance including multiple physician review under paragraph (j)(3)(iii) without cost to employees and at a reasonable time and place.

(2) Biological monitoring.

(i) **Blood lead and ZPP level sampling and analysis.** The employer shall make available biological monitoring in the form of blood sampling and analysis for lead and zinc protoporphyrin levels to each employee covered under paragraphs (j)(1)(i) and (ii) of this section on the following schedule:

(A) For each employee covered under paragraph (j)(1)(ii) of this section, at least every 2 months for the first 6 months and every 6 months thereafter;

(B) For each employee covered under paragraphs (j)(1)(i) or (ii) of this section whose last blood sampling and analysis

indicated a blood lead level at or above 40 µg/dl, at least every two months. This frequency shall continue until two consecutive blood samples and analyses indicate a blood lead level below 40 µg/dl; and

(C) For each employee who is removed from exposure to lead due to an elevated blood lead level at least monthly during the removal period.

(ii) **Follow-up blood sampling tests.** Whenever the results of a blood lead level test indicate that an employee's blood lead level exceeds the numerical criterion for medical removal under paragraph (k)(1)(i) of this section, the employer shall provide a second (follow-up) blood sampling test within two weeks after the employer receives the results of the first blood sampling test.

(iii) **Accuracy of blood lead level sampling and analysis.** Blood lead level sampling and analysis provided pursuant to this section shall have an accuracy (to a confidence level of 95 percent) within plus or minus 15 percent or 6 µg/dl, whichever is greater, and shall be conducted by a laboratory approved by OSHA.

(iv) Employee notification.

(A) Within five working days after the receipt of biological monitoring results, the employer shall notify each employee in writing of his or her blood lead level; and

(B) the employer shall notify each employee whose blood lead level exceeds 40 µg/dl that the standard requires temporary medical removal with Medical Removal Protection benefits when an employee's blood lead level exceeds the numerical criterion for medical removal under paragraph (k)(1)(i) of this section.

(3) Medical examinations and consultations.

(i) **Frequency.** The employer shall make available medical examinations and consultations to each employee covered under paragraph (j)(1)(ii) of this section on the following schedule:

(A) At least annually for each employee for whom a blood sampling test conducted at any time during the preceding 12 months indicated a blood lead level at or above 40 µg/dl;

(B) As soon as possible, upon notification by an employee either that the employee has

developed signs or symptoms commonly associated with lead intoxication, that the employee desires medical advice concerning the effects of current or past exposure to lead on the employee's ability to procreate a healthy child, that the employee is pregnant, or that the employee has demonstrated difficulty in breathing during a respirator fitting test or during use; and

(C) As medically appropriate for each employee either removed from exposure to lead due to a risk of sustaining material impairment to health, or otherwise limited pursuant to a final medical determination.

(ii) **Content.** The content of medical examinations made available pursuant to paragraph (j)(3)(i)(B)-(C) of this section shall be determined by an examining physician and, if requested by an employee, shall include pregnancy testing or laboratory evaluation of male fertility. Medical examinations made available pursuant to paragraph (j)(3)(i)(A) of this section shall include the following elements:

(A) A detailed work history and a medical history, with particular attention to past lead exposure (occupational and non-occupational), personal habits (smoking, hygiene), and past gastrointestinal, hematologic, renal, cardiovascular, reproductive and neurological problems;

(B) A thorough physical examination, with particular attention to teeth, gums, hematologic, gastrointestinal, renal, cardiovascular, and neurological systems. Pulmonary status should be evaluated if respiratory protection will be used;

(C) A blood pressure measurement;

(D) A blood sample and analysis which determines:

(1) Blood lead level;

(2) Hemoglobin and hematocrit determinations, red cell indices, and examination of peripheral smear morphology;

(3) Zinc protoporphyrin;

(4) Blood urea nitrogen; and,

(5) Serum creatinine;

(E) A routine urinalysis with microscopic examination; and

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(F) Any laboratory or other test relevant to lead exposure which the examining physician deems necessary by sound medical practice.

(iii) Multiple physician review mechanism.

(A) If the employer selects the initial physician who conducts any medical examination or consultation provided to an employee under this section, the employee may designate a second physician:

(1) To review any findings, determinations or recommendations of the initial physician; and

(2) To conduct such examinations, consultations, and laboratory tests as the second physician deems necessary to facilitate this review.

(B) The employer shall promptly notify an employee of the right to seek a second medical opinion after each occasion that an initial physician conducts a medical examination or consultation pursuant to this section. The employer may condition its participation in, and payment for, the multiple physician review mechanism upon the employee doing the following within fifteen (15) days after receipt of the foregoing notification, or receipt of the initial physician's written opinion, whichever is later:

(1) The employee informing the employer that he or she intends to seek a second medical opinion, and

(2) The employee initiating steps to make an appointment with a second physician.

(C) If the findings, determinations or recommendations of the second physician differ from those of the initial physician, then the employer and the employee shall assure that efforts are made for the two physicians to resolve any disagreement.

(D) If the two physicians have been unable to quickly resolve their disagreement, then the employer and the employee through their respective physicians shall designate a third physician:

(1) To review any findings, determinations or recommendations of the prior physicians; and

(2) To conduct such examinations, consultations, laboratory tests and discussions with the prior physicians as the third physician deems necessary to resolve the disagreement of the prior physicians.

(E) The employer shall act consistent with the findings, determinations and recommendations of the third physician, unless the employer and the employee reach an agreement which is otherwise consistent with the recommendations of at least one of the three physicians.

(iv) Information provided to examining and consulting physicians.

(A) The employer shall provide an initial physician conducting a medical examination or consultation under this section with the following information:

(1) A copy of this regulation for lead including all Appendices;

(2) A description of the affected employee's duties as they relate to the employee's exposure;

(3) The employee's exposure level or anticipated exposure level to lead and to any other toxic substance (if applicable);

(4) A description of any personal protective equipment used or to be used;

(5) Prior blood lead determinations; and

(6) All prior written medical opinions concerning the employee in the employer's possession or control.

(B) The employer shall provide the foregoing information to a second or third physician conducting a medical examination or consultation under this section upon request either by the second or third physician, or by the employee.

(v) Written medical opinions.

(A) The employer shall obtain and furnish the employee with a copy of a written medical opinion from each examining or consulting physician which contains only the following information:

(1) The physician's opinion as to whether the employee has any detected medical condition which would place the employee at increased risk of material impairment of the employee's health from exposure to lead;

(2) Any recommended special protective measures to be provided to the employee, or limitations to be placed upon the employee's exposure to lead;

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(3) Any recommended limitation upon the employee's use of respirators, including a determination of whether the employee can wear a powered air purifying respirator if a physician determines that the employee cannot wear a negative pressure respirator; and

(4) The results of the blood lead determinations.

(B) The employer shall instruct each examining and consulting physician to:

(1) Not reveal either in the written opinion or orally, or in any other means of communication with the employer, findings, including laboratory results, or diagnoses unrelated to an employee's occupational exposure to lead; and

(2) Advise the employee of any medical condition, occupational or nonoccupational, which dictates further medical examination or treatment.

(vi) Alternate physician determination mechanisms. The employer and an employee or authorized employee representative may agree upon the use of any alternate physician determination mechanism in lieu of the multiple physician review mechanism provided by paragraph (j)(3)(iii) of this section so long as the alternate mechanism is as expeditious and protective as the requirements contained in this paragraph.

(4) Chelation.

(i) The employer shall assure that any person whom he retains, employs, supervises or controls does not engage in prophylactic chelation of any employee at any time.

(ii) If therapeutic or diagnostic chelation is to be performed by any person in paragraph (j)(4)(i) of this section, the employer shall assure that it be done under the supervision of a licensed physician in a clinical setting with thorough and appropriate medical monitoring and that the employee is notified in writing prior to its occurrence.

(k) Medical removal protection.

(1) Temporary medical removal and return of an employee.

(i) **Temporary removal due to elevated blood lead level.** The employer shall remove an employee from work having an exposure to lead at or above the action level on each occasion that a periodic and a follow-up blood sampling test conducted pursuant to this section indicate that the employee's blood lead level is at or above 50 µg/dl; and,

(ii) Temporary removal due to a final medical determination.

(A) The employer shall remove an employee from work having an exposure to lead at or above the action level on each occasion that a final medical determination results in a medical finding, determination, or opinion that the employee has a detected medical condition which places the employee at increased risk of material impairment to health from exposure to lead.

(B) For the purposes of this section, the phrase "final medical determination" means the written medical opinion on the employees' health status by the examining physician or, where relevant, the outcome of the multiple physician review mechanism or alternate medical determination mechanism used pursuant to the medical surveillance provisions of this section.

(C) Where a final medical determination results in any recommended special protective measures for an employee, or limitations on an employee's exposure to lead, the employer shall implement and act consistent with the recommendation.

(iii) Return of the employee to former job status.

(A) The employer shall return an employee to his or her former job status:

(1) For an employee removed due to a blood lead level at or above 50 µg/dl when two consecutive blood sampling tests indicate that the employee's blood lead level is at or below 40 µg/dl;

(2) For an employee removed due to a final medical determination, when a subsequent final medical determination results in a medical finding, determination, or opinion that the employee no longer has a detected medical condition which places the employee at increased risk of material impairment to health from exposure to lead.

(B) For the purposes of this section, the requirement that an employer return an employee to his or her former job status is not intended to expand upon or restrict any rights an employee has or would have had, absent temporary medical removal, to a specific job classification or position under the terms of a collective bargaining agreement.

(iv) Removal of other employee special protective measure or limitations. The employer shall remove any limitations placed on an employee or end any special protective

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measures provided to an employee pursuant to a final medical determination when a subsequent final medical determination indicates that the limitations or special protective measures are no longer necessary.

(v) Employer options pending a final medical determination. Where the multiple physician review mechanism, or alternate medical determination mechanism used pursuant to the medical surveillance provisions of this section, has not yet resulted in a final medical determination with respect to an employee, the employer shall act as follows:

(A) Removal. The employer may remove the employee from exposure to lead, provide special protective measures to the employee, or place limitations upon the employee, consistent with the medical findings, determinations, or recommendations of any of the physicians who have reviewed the employee's health status.

(B) Return. The employer may return the employee to his or her former job status, end any special protective measures provided to the employee, and remove any limitations placed upon the employee, consistent with the medical findings, determinations, or recommendations of any of the physicians who have reviewed the employee's health status, with two exceptions.

If (1) the initial removal, special protection, or limitation of the employee resulted from a final medical determination which differed from the findings, determinations, or recommendations of the initial physician or;

(2) If the employee has been on removal status for the preceding eighteen months due to an elevated blood lead level, then the employer shall await a final medical determination.

(2) Medical removal protection benefits.

(i) Provision of medical removal protection benefits. The employer shall provide an employee up to eighteen (18) months of medical removal protection benefits on each occasion that an employee is removed from exposure to lead or otherwise limited pursuant to this section.

(ii) Definition of medical removal protection benefits. For the purposes of this section, the requirement that an employer provide medical removal protection benefits means that, as long as the job the employee was removed from continues, the employer shall maintain the total

normal earnings, seniority and other employment rights and benefits of an employee, including the employee's right to his or her former job status as though the employee had not been medically removed from the employee's job or otherwise medically limited.

(iii) Follow-up medical surveillance during the period of employee removal or limitation. During the period of time that an employee is medically removed from his or her job or otherwise medically limited, the employer may condition the provision of medical removal protection benefits upon the employee's participation in follow-up medical surveillance made available pursuant to this section.

(iv) Workers' compensation claims. If a removed employee files a claim for workers' compensation payments for a lead-related disability, then the employer shall continue to provide medical removal protection benefits pending disposition of the claim. To the extent that an award is made to the employee for earnings lost during the period of removal, the employer's medical removal protection obligation shall be reduced by such amount. The employer shall receive no credit for workers' compensation payments received by the employee for treatment-related expenses.

(v) Other credits. The employer's obligation to provide medical removal protection benefits to a removed employee shall be reduced to the extent that the employee receives compensation for earnings lost during the period of removal either from a publicly or employer-funded compensation program, or receives income from employment with another employer made possible by virtue of the employee's removal.

(vi) Voluntary removal or restriction of an employee. Where an employer, although not required by this section to do so, removes an employee from exposure to lead or otherwise places limitations on an employee due to the effects of lead exposure on the employee's medical condition, the employer shall provide medical removal protection benefits to the employee equal to that required by paragraph (k)(2)(i) and (ii) of this section.

(I) Employee information and training.

(1) General.

(i) The employer shall communicate information concerning lead hazards according to the requirements of OSHA's Hazard Communication Standard for the construction industry, 29 CFR 1926.59, including but not limited to the

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requirements concerning warning signs and labels, material safety data sheets (MSDS), and employee information and training. In addition, employers shall comply with the following requirements:

(ii) For all employees who are subject to exposure to lead at or above the action level on any day or who are subject to exposure to lead compounds which may cause skin or eye irritation (e.g., lead arsenate, lead azide), the employer shall provide a training program in accordance with paragraph (l)(2) of this section and assure employ participation.

(iii) The employer shall provide the training program as initial training prior to the time of job assignment or prior to the start up date for this requirement, whichever comes last.

(iv) The employer shall also provide the training program at least annually for each employee who is subject to lead exposure at or above the action level on any day.

(2) **Training program.** The employer shall assure that each employee is trained in the following:

(i) The content of this standard and its appendices;

(ii) The specific nature of the operations which could result in exposure to lead above the action level;

(iii) The purpose, proper selection, fitting, use, and limitations of respirators;

(iv) The purpose and a description of the medical surveillance program, and the medical removal protection program including information concerning the adverse health effects associated with excessive exposure to lead (with particular attention to the adverse reproductive effects on both males and females and hazards to the fetus and additional precautions for employees who are pregnant);

(v) The engineering controls and work practices associated with the employee's job assignment including training of employees to follow relevant good work practices described in Appendix B of this section;

(vi) The contents of any compliance plan in effect;

(vii) Instructions to employees that chelating agents should not routinely be used to remove lead from their bodies and should not be used at all except under the direction of a licensed physician; and

(viii) The employee's right of access to records under 29 CFR 1910.20.

(3) Access to information and training materials.

(i) The employer shall make readily available to all affected employees a copy of this standard and its appendices.

(ii) The employer shall provide, upon request, all materials relating to the employee information and training program to affected employees and their designated representatives, and to the Assistant Secretary and the Director.

(m) Signs.

(1) General.

(i) The employer may use signs required by other statutes, regulations or ordinances in addition to, or in combination with, signs required by this paragraph.

(ii) The employer shall assure that no statement appears on or near any sign required by this paragraph which contradicts or detracts from the meaning of the required sign.

(2) Signs.

(i) The employer shall post the following warning signs in each work area where an employees exposure to lead is above the PEL.

**WARNING LEAD WORK AREA POISON
NO SMOKING OR EATING**

(ii) The employer shall assure that signs required by this paragraph are illuminated and cleaned as necessary so that the legend is readily visible.

(n) Recordkeeping.

(1) Exposure assessment.

(i) The employer shall establish and maintain an accurate record of all monitoring and other data used in conducting employee exposure assessments as required in paragraph (d) of this section.

(ii) Exposure monitoring records shall include:

(A) The date(s), number, duration, location and results of each of the samples taken if any, including a description of the sampling procedure used to determine representative employee exposure where applicable;

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(B) A description of the sampling and analytical methods used and evidence of their accuracy;

(C) The type of respiratory protective devices worn, if any;

(D) Name, social security number, and job classification of the employee monitored and of all other employees whose exposure the measurement is intended to represent; and

(E) The environmental variables that could affect the measurement of employee exposure.

(iii) The employer shall maintain monitoring and other exposure assessment records in accordance with the provisions of 29 CFR 1910.20.

(2) Medical surveillance.

(i) The employer shall establish and maintain an accurate record for each employee subject to medical surveillance as required by paragraph (j) of this section.

(ii) This record shall include:

(A) The name, social security number, and description of the duties of the employee;

(B) A copy of the physician's written opinions;

(C) Results of any airborne exposure monitoring done on or for that employee and provided to the physician; and

(D) Any employee medical complaints related to exposure to lead.

(iii) The employer shall keep, or assure that the examining physician keeps, the following medical records:

(A) A copy of the medical examination results including medical and work history required under paragraph (j) of this section;

(B) A description of the laboratory procedures and a copy of any standards or guidelines used to interpret the test results or references to that information;

(C) A copy of the results of biological monitoring.

(iv) The employer shall maintain or assure that the physician maintains medical records in accordance with the provisions of 29 CFR 1910.20.

(3) Medical removals.

(i) The employer shall establish and maintain an accurate record for each employee removed from current exposure to lead pursuant to paragraph (k) of this section.

(ii) Each record shall include:

(A) The name and social security number of the employee;

(B) The date of each occasion that the employee was removed from current exposure to lead as well as the corresponding date on which the employee was returned to his or her former job status;

(C) A brief explanation of how each removal was or is being accomplished; and

(D) A statement with respect to each removal indicating whether or not the reason for the removal was an elevated blood lead level.

(iii) The employer shall maintain each medical removal record for at least the duration of an employee's employment.

(4) Objective data for exemption from requirement for initial monitoring.

(i) For purposes of this section, objective data are information demonstrating that a particular product or material containing lead or a specific process, operation, or activity involving lead cannot release dust or fumes in concentrations at or above the action level under any expected conditions of use. Objective data can be obtained from an industry-wide study or from laboratory product test results from manufacturers of lead containing products or materials. The data the employer uses from an industry-wide survey must be obtained under workplace conditions closely resembling the processes, types of material, control methods, work practices and environmental conditions in the employer's current operations.

(ii) The employer shall maintain the record of the objective data relied upon for at least 30 years.

(5) Availability. The employer shall make available upon request all records required to be maintained by paragraph (n) of this section to affected employees, former employees, and their designated representatives, and to the Assistant Secretary and the Director for examination and copying.

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(6) Transfer of records.

(i) Whenever the employer ceases to do business, the successor employer shall receive and retain all records required to be maintained by paragraph (n) of this section.

(ii) Whenever the employer ceases to do business and there is no successor employer to receive and retain the records required to be maintained by this section for the prescribed period, these records shall be transmitted to the Director.

(iii) At the expiration of the retention period for the records required to be maintained by this section, the employer shall notify the Director at least 3 months prior to the disposal of such records and shall transmit those records to the Director if requested within the period.

(iv) The employer shall also comply with any additional requirements involving transfer of records set forth in 29 CFR 1910.20(h).

(o) Observation of monitoring.

(1) **Employee observation.** The employer shall provide affected employees or their designated representatives an opportunity to observe any monitoring of employee exposure to lead conducted pursuant to paragraph (d) of this section.

(2) Observation procedures.

(i) Whenever observation of the monitoring of employee exposure to lead requires entry into an area where the use of respirators, protective clothing or equipment is required, the employer shall provide the observer with and assure the use of such respirators, clothing and equip-

ment, and shall require the observer to comply with all other applicable safety and health procedures.

(ii) Without interfering with the monitoring, observers shall be entitled to:

(A) Receive an explanation of the measurement procedures;

(B) Observe all steps related to the monitoring of lead performed at the place of exposure; and

(C) Record the results obtained or receive copies of the results when returned by the laboratory.

(p) **Effective date.** This standard (§1926.62) shall become effective June 3, 1993.

(q) **Appendices.** The information contained in the appendices to this section is not intended by itself, to create any additional obligations not otherwise imposed by this standard nor detract from any existing obligation.

(r) Startup dates.

(1) The requirements of paragraphs (c) through (o) of this section, including administrative controls and feasible work practice controls, but not including engineering controls specified in paragraph (e)(1) of this section, shall be complied with as soon as possible, but no later than 60 days from the effective date of this section.

(2) Feasible engineering controls specified by paragraph (e)(1) of this section shall be implemented as soon as possible, but no later than 120 days from the effective date of this section.

Stat. Auth.: ORS 654.025(2) and ORS 656.726(3).
Hist: OR-OSHA Admin. Order 16-1993, f. 11/1/93, ef. 11/1/93 (Lead).

APPENDIX A TO §1926.62 - SUBSTANCE DATA SHEET FOR OCCUPATIONAL EXPOSURE TO LEAD

I. Substance Identification

A. Substance: Pure lead (Pb) is a heavy metal at room temperature and pressure and is a basic chemical element. It can combine with various other substances to form numerous lead compounds.

B. Compounds covered by the standard: The word "lead" when used in this interim final standard means elemental lead, all inorganic lead compounds and a class of organic lead compounds called lead soaps. This standard does not apply to other organic lead compounds.

C. Uses: Exposure to lead occurs in several different occupations in the construction industry, including demolition or salvage of structures where lead or lead-containing materials are present; removal or encapsulation of lead-containing materials, new construction, alteration, repair, or renovation of structures that contain lead or materials containing lead; installation of products containing lead. In addition, there are construction related activities where exposure to lead may occur, including transportation, disposal, storage, or containment of lead or materials containing lead on construction sites, and maintenance operations associated with construction activities.

D. Permissible exposure: The permissible exposure limit (PEL) set by the standard is 50 micrograms of lead per cubic meter of air ($50 \mu\text{g}/\text{m}^3$), averaged over an 8-hour workday.

E. Action level: The interim final standard establishes an action level of 30 micrograms of lead per cubic meter of air ($30 \mu\text{g}/\text{m}^3$), averaged over an 8-hour workday. The action level triggers several ancillary provisions of the standard such as exposure monitoring, medical surveillance, and training.

II. Health Hazard Data

A. Ways in which lead enters your body. When absorbed into your body in certain doses, lead is a toxic substance. The object of the lead standard is to prevent absorption of harmful quantities of lead. The standard is intended to protect you not only from the immediate toxic effects of lead, but also from the serious toxic effects that may not become apparent until years of exposure have passed. Lead can be absorbed into your body by inhalation (breathing) and ingestion (eating). Lead (except for certain organic lead compounds not covered by the standard, such as tetraethyl lead) is not absorbed through your skin. When lead is

scattered in the air as a dust, fume respiratory tract. Inhalation of airborne lead is generally the most important source of occupational lead absorption. You can also absorb lead through your digestive system if lead gets into your mouth and is swallowed. If you handle food, cigarettes, chewing tobacco, or make-up which have lead on them or handle them with hands contaminated with lead, this will contribute to ingestion. A significant portion of the lead that you inhale or ingest gets into your blood stream. Once in your blood stream, lead is circulated throughout your body and stored in various organs and body tissues. Some of this lead is quickly filtered out of your body and excreted, but some remains in the blood and other tissues. As exposure to lead continues, the amount stored in your body will increase if you are absorbing more lead than your body is excreting. Even though you may not be aware of any immediate symptoms of disease, this lead stored in your tissues can be slowly causing irreversible damage, first to individual cells, then to your organs and whole body systems.

B. Effects of overexposure to lead.

(1) Short term (acute) overexposure. Lead is a potent, systemic poison that serves no known useful function once absorbed by your body. Taken in large enough doses, lead can kill you in a matter of days. A condition affecting the brain called acute encephalopathy may arise which develops quickly to seizures, coma, and death from cardiorespiratory arrest. A short term dose of lead can lead to acute encephalopathy. Short term occupational exposures of this magnitude are highly unusual, but not impossible. Similar forms of encephalopathy may, however, arise from extended, chronic exposure to lower doses of lead. There is no sharp dividing line between rapidly developing acute effects of lead, and chronic effects which take longer to acquire. Lead adversely affects numerous body systems, and causes forms of health impairment and disease which arise after periods of exposure as short as days or as long as several years.

(2) Long-term (chronic) overexposure. Chronic overexposure to lead may result in severe damage to your blood-forming, nervous, urinary and reproductive systems. Some common symptoms of chronic overexposure include loss of appetite, metallic taste in the mouth, anxiety, constipation, nausea, pallor, excessive tiredness, weakness, insomnia, headache, nervous irritability, muscle and joint pain or

soreness, fine tremors, numbness, dizziness, hyperactivity and colic. In lead colic there may be severe abdominal pain. Damage to the central nervous system in general and the brain (encephalopathy) in particular is one of the most severe forms of lead poisoning. The most severe, often fatal, form of encephalopathy may be preceded by vomiting, a feeling of dullness progressing to drowsiness and stupor, poor memory, restlessness, irritability, tremor, and convulsions. It may arise suddenly with the onset of seizures, followed by coma, and death. There is a tendency for muscular weakness to develop at the same time. This weakness may progress to paralysis often observed as a characteristic "wrist drop" or "foot drop" and is a manifestation of a disease to the nervous system called peripheral neuropathy. Chronic overexposure to lead also results in kidney disease with few, if any, symptoms appearing until extensive and most likely permanent kidney damage has occurred. Routine laboratory tests reveal the presence of this kidney disease only after about two-thirds of kidney function is lost. When overt symptoms of urinary dysfunction arise, it is often too late to correct or prevent worsening conditions, and progression to kidney dialysis or death is possible. Chronic overexposure to lead impairs the reproductive systems of both men and women. Overexposure to lead may result in decreased sex drive, impotence and sterility in men. Lead can alter the structure of sperm cells raising the risk of birth defects. There is evidence of miscarriage and stillbirth in women whose husbands were exposed to lead or who were exposed to lead themselves. Lead exposure also may result in decreased fertility, and abnormal menstrual cycles in women. The course of pregnancy may be adversely affected by exposure to lead since lead crosses the placental barrier and poses risks to developing fetuses. Children born of parents either one of whom were exposed to excess lead levels are more likely to have birth defects, mental retardation, behavioral disorders or die during the first year of childhood. Overexposure to lead also disrupts the blood-forming system resulting in decreased hemoglobin (the substance in the blood that carries oxygen to the cells) and ultimately anemia. Anemia is characterized by weakness, pallor and fatigability as a result of decreased oxygen carrying capacity in the blood.

(3) Health protection goals of the standard.

Prevention of adverse health effects for most workers from exposure to lead throughout a working lifetime requires that a worker's blood lead level (BLL, also expressed as PbB) be maintained at or below forty micrograms per deciliter of whole blood (40 µg/dl). The blood lead levels of workers (both male and female

workers) who intend to have children should be maintained below 30 µg/dl to minimize adverse reproductive health effects to the parents and to the developing fetus. The measurement of your blood lead level (BLL) is the most useful indicator of the amount of lead being absorbed by your body. Blood lead levels are most often reported in units of milligrams (mg) or micrograms (µg) of lead (1 mg=1000 µg) per 100 grams (100g), 100 milliliters (100 ml) or deciliter (dl) of blood. These three units are essentially the same. Sometime BLLs are expressed in the form of mg% or µg%. This is a shorthand notation for 100g, 100 ml, or dl. (References to BLL measurements in this standard are expressed in the form of µg/dl.)

BLL measurements show the amount of lead circulating in your blood stream, but do not give any information about the amount of lead stored in your various tissues. BLL measurements merely show current absorption of lead, not the effect that lead is having on your body or the effects that past lead exposure may have already caused. Past research into lead-related diseases, however, has focused heavily on associations between BLLs and various diseases. As a result, your BLL is an important indicator of the likelihood that you will gradually acquire a lead-related health impairment or disease.

Once your blood lead level climbs above 40 µg/dl, your risk of disease increases. There is a wide variability of individual response to lead, thus it is difficult to say that a particular BLL in a given person will cause a particular effect. Studies have associated fatal encephalopathy with BLLs as low as 150 µg/dl. Other studies have shown other forms of diseases in some workers with BLLs well below 80 µg/dl. Your BLL is a crucial indicator of the risks to your health, but one other factor is also extremely important. This factor is the length of time you have had elevated BLLs. The longer you have an elevated BLL, the greater the risk that large quantities of lead are being gradually stored in your organs and tissues (body burden). The greater your overall body burden, the greater the chances of substantial permanent damage. The best way to prevent all forms of lead-related impairments and diseases--both short term and long term--is to maintain your BLL below 40 µg/dl. The provisions of the standard are designed with this end in mind.

Your employer has prime responsibility to assure that the provisions of the standard are complied with both by the company and by individual workers. You, as a worker, however, also have a responsibility to assist your employer in complying with the standard. You can play a key role in protecting your own

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health by learning about the lead hazards and their control, learning what the standard requires, following the standard where it governs your own actions, and seeing that your employer complies with provisions governing his or her actions.

(4) Reporting signs and symptoms of health problems. You should immediately notify your employer if you develop signs or symptoms associated with lead poisoning or if you desire medical advice concerning the effects of current or past exposure to lead or your ability to have a healthy child. You should also notify

your employer if you have difficulty breathing during a respirator fit test or while wearing a respirator. In each of these cases, your employer must make available to you appropriate medical examinations or consultations. These must be provided at no cost to you and at a reasonable time and place. The standard contains a procedure whereby you can obtain a second opinion by a physician of your choice if your employer selected the initial physician.

Stat. Auth.: ORS 654.025(2) and ORS 656.726(3).

Hist: OR-OSHA Admin. Order 16-1993, f. 11/1/93, ef. 11/1/93 (Lead).

APPENDIX B TO §1926.62 - EMPLOYEE STANDARD SUMMARY

This appendix summarizes key provisions of the interim final standard for lead in construction that you as a worker should become familiar with.

I. Permissible Exposure Limit (PEL) - Paragraph (C)

The standard sets a permissible exposure limit (PEL) of 50 micrograms of lead per cubic meter of air ($50 \mu\text{g}/\text{m}^3$), averaged over an 8-hour workday which is referred to as a time-weighted average (TWA). This is the highest level of lead in air to which you may be permissibly exposed over an 8-hour workday. However, since this is an 8-hour average, short exposures above the PEL are permitted so long as for each 8-hour work day your average exposure does not exceed this level. This interim final standard, however, takes into account the fact that your daily exposure to lead can extend beyond a typical 8-hour workday as the result of overtime or other alterations in your work schedule. To deal with this situation, the standard contains a formula which reduces your permissible exposure when you are exposed more than 8 hours. For example, if you are exposed to lead for 10 hours a day, the maximum permitted average exposure would be $40 \mu\text{g}/\text{m}^3$.

II. Exposure Assessment - Paragraph (D)

If lead is present in your workplace in any quantity, your employer is required to make an initial determination of whether any employee's exposure to lead exceeds the action level ($30 \mu\text{g}/\text{m}^3$ averaged over an 8-hour day). Employee exposure is that exposure which would occur if the employee were not using a respirator. This initial determination requires your employer to monitor workers' exposures unless he or she has objective data which can demonstrate conclusively that no employee will be exposed to lead in excess of the action level. Where objective data is used in lieu of actual monitoring the employer must establish and maintain an accurate record, documenting its relevancy in assessing exposure levels for current job conditions. If such objective data is available, the employer need proceed no further on employee exposure assessment until such time that conditions have changed and the determination is no longer valid.

Objective data may be compiled from various sources, e.g., insurance companies and trade associations and information from suppliers or exposure data collected from similar operations. Objective data may also comprise previously-collected sampling data including area monitoring. If it cannot be determined through using objective data that worker exposure is less than the action level, your employer must conduct monitoring or must rely on relevant previous personal sampling, if available. Where monitoring is required for the

initial determination, it may be limited to a representative number of employees who are reasonably expected to have the highest exposure levels. If your employer has conducted appropriate air sampling for lead in the past 12 months, he or she may use these results, provided they are applicable to the same employee tasks and exposure conditions and meet the requirements for accuracy as specified in the standard. As with objective data, if such results are relied upon for the initial determination, your employer must establish and maintain a record as to the relevancy of such data to current job conditions.

If there have been any employee complaints of symptoms which may be attributable to exposure to lead or if there is any other information or observations which would indicate employee exposure to lead, this must also be considered as part of the initial determination.

If this initial determination shows that a reasonable possibility exists that any employee may be exposed, without regard to respirators, over the action level, your employer must set up an air monitoring program to determine the exposure level representative of each employee exposed to lead at your workplace. In carrying out this air monitoring program, your employer is not required to monitor the exposure of every employee, but he or she must monitor a representative number of employees and job types. Enough sampling must be done to enable each employee's exposure level to be reasonably represent full shift exposure. In addition, these air samples must be taken under conditions which represent each employee's regular, daily exposure to lead. Sampling performed in the past 12 months may be used to determine exposures above the action level if such sampling was conducted during work activities essentially similar to present work conditions.

The standard lists certain tasks which may likely result in exposures to lead in excess of the PEL and, in some cases, exposures in excess of 50 times the PEL. If you are performing any of these tasks, your employer must provide you with appropriate respiratory protection, protective clothing and equipment, change areas, hand washing facilities, biological monitoring, and training until such time that an exposure assessment is conducted which demonstrates that your exposure level is below the PEL.

If you are exposed to lead and air sampling is performed, your employer is required to notify you in writing within 5 working days of the air monitoring results which represent your exposure. If the results indicate that your exposure exceeds

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the PEL (without regard to your use of a respirator), then your employer must also notify you of this in writing, and provide you with a description of the corrective action that has been taken or will be taken to reduce your exposure.

Your exposure must be rechecked by monitoring, at least every six months if your exposure is at or over the action level but below the PEL. Your employer may discontinue monitoring for you if 2 consecutive measurements, taken at least 7 days apart, are at or below the action level. Air monitoring must be repeated every 3 months if you are exposed over the PEL. Your employer must continue monitoring for you at this frequency until 2 consecutive measurements, taken at least 7 days apart, are below the PEL but above the action level, at which time your employer must repeat monitoring of your exposure every six months and may discontinue monitoring only after your exposure drops to or below the action level. However, whenever there is a change of equipment, process, control, or personnel or a new type of job is added at your workplace which may result in new or additional exposure to lead, your employer must perform additional monitoring.

III. Methods of Compliance – Paragraph (E)

Your employer is required to assure that no employee is exposed to lead in excess of the PEL as an 8-hour TWA. The interim final standard for lead in construction requires employers to institute engineering and work practice controls including administrative controls to the extent feasible to reduce employee exposure to lead. Where such controls are feasible but not adequate to reduce exposures below the PEL they must be used nonetheless to reduce exposures to the lowest level that can be accomplished by these means and then supplemented with appropriate respiratory protection.

Your employer is required to develop and implement a written compliance program prior to the commencement of any job where employee exposures may reach the PEL as an 8-hour TWA. The interim final standard identifies the various elements that must be included in the plan. For example, employers are required to include a description of operations in which lead is emitted, detailing other relevant information about the operation such as the type of equipment used, the type of material involved, employee job responsibilities, operating procedures and maintenance practices. In addition, your employer's compliance plan must specify the means that will be used to achieve compliance and, where engineering controls are required, include any engineering plans or studies that have been used to select the control methods. If administrative controls involving job rotation are used to reduce employee exposure to lead, the

job rotation schedule must be included in the compliance plan. The plan must also detail the type of protective clothing and equipment, including respirators, housekeeping and hygiene practices that will be used to protect you from the adverse effects of exposure to lead.

The written compliance program must be made available, upon request, to affected employees and their designated representatives, the Assistant Secretary and the Director. Finally, the plan must be reviewed and updated at least every 6 months to assure it reflects the current status in exposure control.

IV. Respiratory Protection – Paragraph (F)

Your employer is required to provide and assure your use of respirators when your exposure to lead is not controlled below the PEL by other means. The employer must pay the cost of the respirator. Whenever you request one, your employer is also required to provide you a respirator even if your air exposure level is not above the PEL. You might desire a respirator when, for example, you have received medical advice that your lead absorption should be decreased. Or, you may intend to have children in the near future, and want to reduce the level of lead in your body to minimize adverse reproductive effects. While respirators are the least satisfactory means of controlling your exposure, they are capable of providing significant protection if properly chosen, fitted, worn, cleaned, maintained, and replaced when they stop providing adequate protection.

Your employer is required to select respirators from the types listed in Table I of the Respiratory Protection section of the standard. Any respirator chosen must be approved by the Mine Safety and Health Administration (MSHA) or the National Institute for Occupational Safety and Health (NIOSH). This respirator selection table will enable your employer to choose a type of respirator which will give you a proper amount of protection based on your airborne lead exposure. Your employer may select a type of respirator that provides greater protection than that required by the standard; that is, one recommended for a higher concentration of lead than is present in your workplace. For example, a powered air purifying respirator (PAPR) is much more protective than a typical negative pressure respirator, and may also be more comfortable to wear. A PAPR has a filter, cartridge or canister to clean the air, and a power source which continuously blows filtered air into your breathing zone. Your employer might make a PAPR available to you to ease the burden of having to wear a respirator for long periods of time. The standard provides that you can obtain a PAPR upon request.

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Your employer must also start a Respiratory Protection Program. This program must include written procedures for the proper selection, use, cleaning, storage, and maintenance of respirators.

Your employer must assure that your respirator facepiece fits properly. Proper fit of a respirator facepiece is critical. Obtaining a proper fit on each employee may require your employer to make available two or three different mask types. In order to assure that your respirator fits properly and that facepiece leakage is minimized, your employer must give you either a qualitative fit test or a quantitative fit test (if you use a negative pressure respirator) in accordance with appendix D. Any respirator which has a filter, cartridge or canister which cleans the work room air before you breathe it and which requires the force of your inhalation to draw air through the filtering element is a negative pressure respirator. A positive pressure respirator supplies air to you directly. A quantitative fit test uses a sophisticated machine to measure the amount, if any, of test material that leaks into the facepiece of your respirator.

You must also receive from your employer proper training in the use of respirators. Your employer is required to teach you how to wear a respirator, to know why it is needed, and to understand its limitations.

Your employer must test the effectiveness of your negative pressure respirator initially and at least every six months thereafter with a "qualitative fit test." In this test, the fit of the facepiece is checked by seeing if you can smell a substance placed outside the respirator. If you can, there is appreciable leakage where the facepiece meets your face.

The standard provides that if your respirator uses filter elements, you must be given an opportunity to change the filter elements whenever an increase in breathing resistance is detected. You also must be permitted to periodically leave your work area to wash your face and respirator facepiece whenever necessary to prevent skin irritation. If you ever have difficulty in breathing during a fit test or while using a respirator, your employer must make a medical examination available to you to determine whether you can safely wear a respirator. The result of this examination may be to give you a positive pressure respirator (which reduces breathing resistance) or to provide alternative means of protection.

V. Protective Work Clothing and Equipment - Paragraph (G)

If you are exposed to lead above the PEL as an 8-hour TWA, without regard to your use of a respirator, or if you are exposed to lead compounds such as lead arsenate or lead azide

which can cause skin and eye irritation, your employer must provide you with protective work clothing and equipment appropriate for the hazard. If work clothing is provided, it must be provided in a clean and dry condition at least weekly, and daily if your airborne exposure to lead is greater than 200 $\mu\text{g}/\text{m}^3$. Appropriate protective work clothing and equipment can include coveralls or similar full-body work clothing, gloves, hats, shoes or disposable shoe coverlets, and face shields or vented goggles. Your employer is required to provide all such equipment at no cost to you. In addition, your employer is responsible for providing repairs and replacement as necessary, and also is responsible for the cleaning, laundering or disposal of protective clothing and equipment.

The interim final standard requires that your employer assure that you follow good work practices when you are working in areas where your exposure to lead may exceed the PEL. With respect to protective clothing and equipment, where appropriate, the following procedures should be observed prior to beginning work:

1. Change into work clothing and shoe covers in the clean section of the designated changing areas;
2. Use work garments of appropriate protective gear, including respirators before entering the work area; and
3. Store any clothing not worn under protective clothing in the designated changing area.

Workers should follow these procedures upon leaving the work area:

1. HEPA vacuum heavily contaminated protective work clothing while it is still being worn. At no time may lead be removed from protective clothing by any means which result in uncontrolled dispersal of lead into the air;
2. Remove shoe covers and leave them in the work area;
3. Remove protective clothing and gear in the dirty area of the designated changing area. Remove protective coveralls by carefully rolling down the garment to reduce exposure to dust.
4. Remove respirators last; and
5. Wash hands and face.

Workers should follow these procedures upon finishing work for the day (in addition to procedures described above):

1. Where applicable, place disposal coveralls and shoe covers with the abatement waste;

2. Contaminated clothing which is to be cleaned, laundered or disposed of must be placed in closed containers in the change room.

3. Clean protective gear, including respirators, according to standard procedures;

4. Wash hands and face again. If showers are available, take a shower and wash hair. If shower facilities are not available at the work site, shower immediately at home and wash hair.

VI. Housekeeping – Paragraph (H)

Your employer must establish a housekeeping program sufficient to maintain all surfaces as free as practicable of accumulations of lead dust. Vacuuming is the preferred method of meeting this requirement, and the use of compressed air to clean floors and other surfaces is generally prohibited unless removal with compressed air is done in conjunction with ventilation systems designed to contain dispersal of the lead dust. Dry or wet sweeping, shoveling, or brushing may not be used except where vacuuming or other equally effective methods have been tried and do not work. Vacuums must be used equipped with a special filter called a high-efficiency particulate air (HEPA) filter and emptied in a manner which minimizes the reentry of lead into the workplace.

VII. Hygiene Facilities and Practices – Paragraph (I)

The standard requires that hand washing facilities be provided where occupational exposure to lead occurs. In addition, change areas, showers (where feasible), and lunchrooms or eating areas are to be made available to workers exposed to lead above the PEL. Your employer must assure that except in these facilities, food and beverage is not present or consumed, tobacco products are not present or used, and cosmetics are not applied, where airborne exposures are above the PEL. Change rooms provided by your employer must be equipped with separate storage facilities for your protective clothing and equipment and street clothes to avoid cross-contamination. After showering, no required protective clothing or equipment worn during the shift may be worn home. It is important that contaminated clothing or equipment be removed in change areas and not be worn home or you will extend your exposure and expose your family since lead from your clothing can accumulate in your house, car, etc.

Lunchrooms or eating areas may not be entered with protective clothing or equipment unless surface dust has been removed by vacuuming, downdraft booth, or other cleaning method. Finally, workers exposed above the PEL must wash both their hands and faces prior to eating, drinking, smoking or applying cosmetics.

All of the facilities and hygiene practices just discussed are essential to minimize additional sources of lead absorption from inhalation or ingestion of lead that may accumulate on you, your clothes, or your possessions. Strict compliance with these provisions can virtually eliminate several sources of lead exposure which significantly contribute to excessive lead absorption.

VIII. Medical Surveillance – Paragraph (J)

The medical surveillance program is part of the standard's comprehensive approach to the prevention of lead-related disease. Its purpose is to supplement the main thrust of the standard which is aimed at minimizing airborne concentrations of lead and sources of ingestion. Only medical surveillance can determine if the other provisions of the standard have effectively protected you as an individual. Compliance with the standard's provision will protect most workers from the adverse effects of lead exposure, but may not be satisfactory to protect individual workers (1) who have high body burdens of lead acquired over past years, (2) who have additional uncontrolled sources of non-occupational lead exposure, (3) who exhibit unusual variations in lead absorption rates, or (4) who have specific non-work related medical conditions which could be aggravated by lead exposure (e.g., renal disease, anemia). In addition, control systems may fail, or hygiene and respirator programs may be inadequate. Periodic medical surveillance of individual workers will help detect those failures. Medical surveillance will also be important to protect your reproductive ability—regardless of whether you are a man or woman.

All medical surveillance required by the interim final standard must be performed by or under the supervision of a licensed physician. The employer must provide required medical surveillance without cost to employees and at a reasonable time and place. The standard's medical surveillance program has two parts—periodic biological monitoring and medical examinations. Your employer's obligation to offer you medical surveillance is triggered by the results of the air monitoring program. Full medical surveillance must be made available to all employees who are or may be exposed to lead in excess of the action level for more than 30 days a year and whose blood lead level exceeds 40 µg/dl. Initial medical surveillance consisting of blood sampling and analysis for lead and zinc protoporphyrin must be provided to all employees exposed at any time (1 day) above the action level.

Biological monitoring under the standard must be provided at least every 2 months for the first 6 months and every 6 months thereafter until your blood lead level is below 40 µg/dl. A zinc

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protoporphyrin (ZPP) test is a very useful blood test which measures an adverse metabolic effect of lead on your body and is therefore an indicator of lead toxicity.

If your BLL exceeds 40 µg/dl the monitoring frequency must be increased from every 6 months to at least every 2 months and not reduced until two consecutive BLLs indicate a blood lead level below 40 µg/dl. Each time your BLL is determined to be over 40 µg/dl, your employer must notify you of this in writing within five working days of his or her receipt of the test results. The employer must also inform you that the standard requires temporary medical removal with economic protection when your BLL exceeds 50 µg/dl. (See Discussion of Medical Removal Protection-Paragraph (k).) Anytime your BLL exceeds 50 µg/dl your employer must make available to you within two weeks of receipt of these test results a second follow-up BLL test to confirm your BLL. If the two tests both exceed 50 µg/dl, and you are temporarily removed, then your employer must make successive BLL tests available to you on a monthly basis during the period of your removal.

Medical examinations beyond the initial one must be made available on an annual basis if your blood lead level exceeds 40 µg/dl at any time during the preceding year and you are being exposed above the airborne action level of 30 µg/m³ for 30 or more days per year. The initial examination will provide information to establish a baseline to which subsequent data can be compared.

An initial medical examination to consist of blood sampling and analysis for lead and zinc protoporphyrin must also be made available (prior to assignment) for each employee being assigned for the first time to an area where the airborne concentration of lead equals or exceeds the action level at any time. In addition, a medical examination or consultation must be made available as soon as possible if you notify your employer that you are experiencing signs or symptoms commonly associated with lead poisoning or that you have difficulty breathing while wearing a respirator or during a respirator fit test. You must also be provided a medical examination or consultation if you notify your employer that you desire medical advice concerning the effects of current or past exposure to lead on your ability to procreate a healthy child.

Finally, appropriate follow-up medical examinations or consultations may also be provided for employees who have been temporarily removed from exposure under the medical removal protection provisions of the standard. (See Part IX, below.)

The standard specifies the minimum content of pre-assignment and annual medical examinations. The content of other types of medical examinations and consultations is left up to the sound discretion of the examining physician. Pre-assignment and annual medical examinations must include (1) a detailed work history and medical history; (2) a thorough physical examination, including an evaluation of your pulmonary status if you will be required to use a respirator; (3) a blood pressure measurement; and (4) a series of laboratory tests designed to check your blood chemistry and your kidney function. In addition, at any time upon your request, a laboratory evaluation of male fertility will be made (microscopic examination of a sperm sample), or a pregnancy test will be given.

The standard does not require that you participate in any of the medical procedures, tests, etc., which your employer is required to make available to you. Medical surveillance can, however, play a very important role in protecting your health. You are strongly encouraged, therefore, to participate in a meaningful fashion. The standard contains a multiple physician review mechanism which will give you a chance to have a physician of your choice directly participate in the medical surveillance program. If you are dissatisfied with an examination by a physician chosen by your employer, you can select a second physician to conduct an independent analysis. The two doctors would attempt to resolve any differences of opinion, and select a third physician to resolve any firm dispute. Generally your employer will choose the physician who conducts medical surveillance under the lead standard-unless you and your employer can agree on the choice of a physician or physicians. Some companies and unions have agreed in advance, for example, to use certain independent medical laboratories or panels of physicians. Any of these arrangements are acceptable so long as required medical surveillance is made available to workers.

The standard requires your employer to provide certain information to a physician to aid in his or her examination of you. This information includes (1) the standard and its appendices, (2) a description of your duties as they relate to occupational lead exposure, (3) your exposure level or anticipated exposure level, (4) a description of any personal protective equipment you wear, (5) prior blood lead level results, and (6) prior written medical opinions concerning you that the employer has. After a medical examination or consultation the physician must prepare a written report which must contain (1) the physician's opinion as to whether you have any medical condition which places you at increased risk of material impairment to health from exposure to lead, (2) any

recommended special protective measures to be provided to you, (3) any blood lead level determinations, and (4) any recommended limitation on your use of respirators. This last element must include a determination of whether you can wear a powered air purifying respirator (PAPR) if you are found unable to wear a negative pressure respirator.

The medical surveillance program of the interim lead standard may at some point in time serve to notify certain workers that they have acquired a disease or other adverse medical condition as a result of occupational lead exposure. If this is true, these workers might have legal rights to compensation from public agencies, their employers, firms that supply hazardous products to their employers, or other persons. Some states have laws, including worker compensation laws, that disallow a worker who learns of a job-related health impairment to sue, unless the worker sues within a short period of time after learning of the impairment. (This period of time may be a matter of months or years.) An attorney can be consulted about these possibilities. It should be stressed that OSHA is in no way trying to either encourage or discourage claims or lawsuits. However, since results of the standard's medical surveillance program can significantly affect the legal remedies of a worker who has acquired a job-related disease or impairment, it is proper for OSHA to make you aware of this.

The medical surveillance section of the standard also contains provisions dealing with chelation. Chelation is the use of certain drugs (administered in pill form or injected into the body) to reduce the amount of lead absorbed in body tissues. Experience accumulated by the medical and scientific communities has largely confirmed the effectiveness of this type of therapy for the treatment of very severe lead poisoning. On the other hand, it has also been established that there can be a long list of extremely harmful side effects associated with the use of chelating agents. The medical community has balanced the advantages and disadvantages resulting from the use of chelating agents in various circumstances and has established when the use of these agents is acceptable. The standard includes these accepted limitations due to a history of abuse of chelation therapy by some lead companies. The most widely used chelating agents are calcium disodium EDTA, (Ca Na₂ EDTA), Calcium Disodium Versenate (Versenate), and d-penicillamine (pencillamine or Cupramine).

The standard prohibits "prophylactic chelation" of any employee by any person the employer retains, supervises or controls. "Prophylactic chelation" is the routine use of chelating or similarly acting drugs to prevent elevated blood levels in workers who are occupationally exposed to lead, or the use of these drugs to routinely

lower blood lead levels to predesignated concentrations believed to be "safe". It should be emphasized that where an employer takes a worker who has no symptoms of lead poisoning and has chelation carried out by a physician (either inside or outside of a hospital) solely to reduce the worker's blood lead level, that will generally be considered prophylactic chelation. The use of a hospital and a physician does not mean that prophylactic chelation is not being performed. Routine chelation to prevent increased or reduce current blood lead levels is unacceptable whatever the setting.

The standard allows the use of "therapeutic" or "diagnostic" chelation if administered under the supervision of a licensed physician in a clinical setting with thorough and appropriate medical monitoring. Therapeutic chelation responds to severe lead poisoning where there are marked symptoms. Diagnostic chelation involved giving a patient a dose of the drug then collecting all urine excreted for some period of time as an aid to the diagnosis of lead poisoning.

In cases where the examining physician determines that chelation is appropriate, you must be notified in writing of this fact before such treatment. This will inform you of a potentially harmful treatment, and allow you to obtain a second opinion.

IX. Medical Removal Protection - Paragraph (K)

Excessive lead absorption subjects you to increased risk of disease. Medical removal protection (MRP) is a means of protecting you when, for whatever reasons, other methods, such as engineering controls, work practices, and respirators, have failed to provide the protection you need. MRP involves the temporary removal of a worker from his or her regular job to a place of significantly lower exposure without any loss of earnings, seniority, or other employment rights or benefits. The purpose of this program is to cease further lead absorption and allow your body to naturally excrete lead which has previously been absorbed. Temporary medical removal can result from an elevated blood lead level, or a medical opinion. For up to 18 months, or for as long as the job the employee was removed from lasts, protection is provided as a result of either form of removal. The vast majority of removed workers, however, will return to their former jobs long before this eighteen month period expires.

You may also be removed from exposure even if your blood lead level is below 50 µg/dl if a final medical determination indicates that you temporarily need reduced lead exposure for medical reasons. If the physician who is implementing your employers medical program makes a final written opinion recommending your removal or other special protective measures, your employer

must implement the physician's recommendation. If you are removed in this manner, you may only be returned when the doctor indicates that it is safe for you to do so.

The standard does not give specific instructions dealing with what an employer must do with a removed worker. Your job assignment upon removal is a matter for you, your employer and your union (if any) to work out consistent with existing procedures for job assignments. Each removal must be accomplished in a manner consistent with existing collective bargaining relationships. Your employer is given broad discretion to implement temporary removals so long as no attempt is made to override existing agreements. Similarly, a removed worker is provided no right to veto an employer's choice which satisfies the standard.

In most cases, employers will likely transfer removed employees to other jobs with sufficiently low lead exposure. Alternatively, a worker's hours may be reduced so that the time weighted average exposure is reduced, or he or she may be temporarily laid off if no other alternative is feasible.

In all of these situation, MRP benefits must be provided during the period of removal--i.e., you continue to receive the same earnings, seniority, and other rights and benefits you would have had if you had not been removed. Earnings includes more than just your base wage; it includes overtime, shift differentials, incentives, and other compensation you would have earned if you had not been removed. During the period of removal you must also be provided with appropriate follow-up medical surveillance. If you were removed because your blood lead level was too high, you must be provided with a monthly blood test. If a medical opinion caused your removal, you must be provided medical tests or examinations that the doctor believes to be appropriate. If you do not participate in this follow up medical surveillance, you may lose your eligibility for MRP benefits.

When you are medically eligible to return to your former job, your employer must return you to your "former job status." This means that you are entitled to the position, wages, benefits, etc., you would have had if you had not been removed. If you would still be in your old job if no removal had occurred that is where you go back. If not, you are returned consistent with whatever job assignment discretion your employer would have had if no removal had occurred. MRP only seeks to maintain your rights, not expand them or diminish them.

If you are removed under MRP and you are also eligible for worker compensation or other compensation for lost wages, your employer's MRP benefits obligation is reduced by the amount that you actually receive from these other sources. This is also true if you obtain other employment during the time you are laid off with MRP benefits.

The standard also covers situations where an employer voluntarily removes a worker from exposure to lead due to the effects of lead on the employee's medical condition, even though the standard does not require removal. In these situations MRP benefits must still be provided as though the standard required removal. Finally, it is important to note that in all cases where removal is required, respirators cannot be used as a substitute. Respirators may be used before removal becomes necessary, but not as an alternative to a transfer to a low exposure job, or to a lay-off with MRP benefits.

X. Employee Information and Training – Paragraph (L)

Your employer is required to provide an information and training program for all employees exposed to lead above the action level or who may suffer skin or eye irritation from lead compounds such as lead arsenate or lead azide. The program must train these employees regarding the specific hazards associated with their work environment, protective measures which can be taken, including the contents of any compliance plan in effect, the danger of lead to their bodies (including their reproductive systems), and their rights under the standard. All employees must be trained prior to initial assignment to areas where there is a possibility of exposure over the action level.

This training program must also be provided at least annually thereafter unless further exposure above the action level will not occur.

XI. Signs – Paragraph (M)

The standard requires that the following warning sign be posted in work areas where the exposure to lead exceeds the PEL:

**WARNING
LEAD WORK AREA
POISON
NO SMOKING OR EATING**

These signs are to be posted and maintained in a manner which assures that the legend is readily visible.

XII. Recordkeeping – Paragraph (N)

Your employer is required to keep all records of exposure monitoring for airborne lead. These records must include the name and job classification of employees measured, details of the sampling and analytical techniques, the results of this sampling, and the type of respiratory protection being worn by the person sampled. Such records are to be retained for at least 30 years. Your employer is also required to keep all records of biological monitoring and medical examination results. These records must include the names of the employees, the physician's written opinion, and a copy of the results of the examination. Medical records must be preserved and maintained for the duration of employment plus 30 years. However, if the employee's duration of employment is less than one year, the employer need not retain that employee's medical records beyond the period of employment if they are provided to the employee upon termination of employment.

Recordkeeping is also required if you are temporarily removed from your job under the medical removal protection program. This record must include your name and social security number, the date of your removal and return, how the removal was or is being accomplished, and whether or not the reason for the removal was an elevated blood lead level. Your employer is required to keep each medical removal record only for as long as the duration of an employee's employment.

The standard requires that if you request to see or copy environmental monitoring, blood lead level monitoring, or medical removal records, they must be made available to you or to a representative that you authorize. Your union also has access to these records. Medical records other than BLL's must also be provided upon request to you, to your physician or to any other person whom you may specifically designate. Your union does not have access to your personal medical records unless you authorize their access.

XIII. Observation of Monitoring – Paragraph (O)

When air monitoring for lead is performed at your workplace as required by this standard, your employer must allow you or someone you designate to act as an observer of the monitoring. Observers are entitled to an explanation of the measurement procedure, and to record the results obtained. Since results will not normally be available at the time of the monitoring, observers are entitled to record or receive the results of the monitoring when returned by the laboratory. Your employer is required to provide the observer with any personal protective devices required to be worn by employees working in the area that is being monitored. The employer must require the observer to wear all such equipment and to comply with all other applicable safety and health procedures.

XIV. Effective Date – Paragraph (P)

The standard's effective date is June 3, 1993. Employer obligations under the standard begin as of that date with full implementation of engineering controls as soon as possible but no later than within 4 months, and all other provisions completed as soon as possible, but no later than within 2 months from the effective date.

XV. For Additional Information

- A. A copy of the interim standard for lead in construction can be obtained free of charge by calling or writing the OSHA Office of Publications, room N-3101, United States Department of Labor, Washington, DC 20210: Telephone (202) 219-4667.
- B. Additional information about the standard, its enforcement, and your employer's compliance can be obtained from the nearest OSHA Area Office listed in your telephone directory under United States Government/Department of Labor.

Stat. Auth.: ORS 654.025(2) and ORS 656.726(3).

Hist: OR-OSHA Admin. Order 16-1993, f. 11/1/93, ef. 11/1/93 (Lead).

APPENDIX C TO §1926.62 - MEDICAL SURVEILLANCE GUIDELINES

Introduction

The primary purpose of the Occupational Safety and Health Act of 1970 is to assure, so far as possible, safe and healthful working conditions for every working man and woman. The interim final occupational health standard for lead in construction is designed to protect workers exposed to inorganic lead including metallic lead, all inorganic lead compounds and organic lead soaps.

Under this interim final standard occupational exposure to inorganic lead is to be limited to $50 \mu\text{g}/\text{m}^3$ (micrograms per cubic meter) based on an 8 hour time-weighted average (TWA). This permissible exposure limit (PEL) must be achieved through a combination of engineering, work practice and administrative controls to the extent feasible. Where these controls are in place but are found not to reduce employee exposures to or below the PEL, they must be used nonetheless, and supplemented with respirators to meet the $50 \mu\text{g}/\text{m}^3$ exposure limit.

The standard also provides for a program of biological monitoring for employees exposed to lead above the action level at any time, and additional medical surveillance for all employees exposed to levels of inorganic lead above $30 \mu\text{g}/\text{m}^3$ (TWA) for more than 30 days per year and whose BLL exceeds $40 \mu\text{g}/\text{dl}$. The purpose of this document is to outline the medical surveillance provisions of the interim standard for inorganic lead in construction, and to provide further information to the physician regarding the examination and evaluation of workers exposed to inorganic lead.

Section 1 provides a detailed description of the monitoring procedure including the required frequency of blood testing for exposed workers, provisions for medical removal protection (MRP), the recommended right of the employee to a second medical opinion, and notification and recordkeeping requirements of the employer. A discussion of the requirements for respirator use and respirator monitoring and OSHA's position on prophylactic chelation therapy are also included in this section.

Section 2 discusses the toxic effects and clinical manifestations of lead poisoning and effects of lead intoxication on enzymatic pathways in heme synthesis. The adverse effects on both male and female reproductive capacity and on the fetus are also discussed.

Section 3 outlines the recommended medical evaluation of the worker exposed to inorganic lead, including details of the medical history, physical examination, and recommended laboratory tests, which are based on the toxic effects of lead as discussed in Section 2.

Section 4 provides detailed information concerning the laboratory tests available for the monitoring of exposed workers. Included also is a discussion of the relative value of each test and the limitations and precautions which are necessary in the interpretation of the laboratory results.

I. Medical Surveillance and Monitoring Requirements for Workers Exposed to Inorganic Lead

Under the interim final standard for inorganic lead in the construction industry, initial medical surveillance consisting of biological monitoring to include blood lead and ZPP level determination shall be provided to employees exposed to lead at or above the action level on any one day. In addition, a program of biological monitoring is to be made available to all employees exposed above the action level at any time and additional medical surveillance is to be made available to all employees exposed to lead above $30 \mu\text{g}/\text{m}^3$ TWA for more than 30 days each year and whose BLL exceeds $40 \mu\text{g}/\text{dl}$. This program consists of periodic blood sampling and medical evaluation to be performed on a schedule which is defined by previous laboratory results, worker complaints or concerns, and the clinical assessment of the examining physician.

Under this program, the blood lead level (BLL) of all employees who are exposed to lead above $30 \mu\text{g}/\text{m}^3$ for more than 30 days per year or whose blood lead is above $40 \mu\text{g}/\text{dl}$ but exposed for no more than 30 days per year is to be determined at least every two months for the first six months of exposure and every six months thereafter. The frequency is increased to every two months for employees whose last blood lead level was $40 \mu\text{g}/\text{dl}$ or above. For employees who are removed from exposure to lead due to an elevated blood lead, a new blood lead level must be measured monthly. A zinc protoporphyrin (ZPP) measurement is strongly recommended on each occasion that a blood lead level measurement is made.

An annual medical examination and consultation performed under the guidelines discussed in Section 3 is to be made available to each employee exposed above $30 \mu\text{g}/\text{m}^3$ for more than 30 days per year for whom a blood test conducted at any time during the preceding 12 months indicated a blood lead level at or above $40 \mu\text{g}/\text{dl}$. Also, an examination is to be given to all employees prior to their assignment to an area in which airborne lead concentrations reach or exceed the $30 \mu\text{g}/\text{m}^3$ for more than 30 days per year. In addition, a medical examination must be provided as soon as possible after notification by an employee that the employee has developed

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signs or symptoms commonly associated with lead intoxication, that the employee desires medical advice regarding lead exposure and the ability to procreate a healthy child, or that the employee has demonstrated difficulty in breathing during a respirator fitting test or during respirator use. An examination is also to be made available to each employee removed from exposure to lead due to a risk of sustaining material impairment to health, or otherwise limited or specially protected pursuant to medical recommendations.

Results of biological monitoring or the recommendations of an examining physician may necessitate removal of an employee from further lead exposure pursuant to the standard's medical removal protection (MRP) program. The object of the MRP program is to provide temporary medical removal to workers either with substantially elevated blood lead levels or otherwise at risk of sustaining material health impairment from continued substantial exposure to lead.

Under the standard's ultimate worker removal criteria, a worker is to be removed from any work having an eight hour TWA exposure to lead of $30 \mu\text{g}/\text{m}^3$ when his or her blood lead level reaches $50 \mu\text{g}/\text{dl}$ and is confirmed by a second follow-up blood lead level performed within two weeks after the employer receives the results of the first blood sampling test. Return of the employee to his or her job status depends on a worker's blood lead level declining to $40 \mu\text{g}/\text{dl}$.

As part of the interim standard, the employer is required to notify in writing each employee whose blood lead level exceeds $40 \mu\text{g}/\text{dl}$. In addition each such employee is to be informed that the standard requires medical removal with MRP benefits, discussed below, when an employee's blood lead level exceeds the above defined limit.

In addition to the above blood lead level criterion, temporary worker removal may also take place as a result of medical determinations and recommendations. Written medical opinions must be prepared after each examination pursuant to the standard. If the examining physician includes a medical finding, determination or opinion that the employee has a medical condition which places the employee at increased risk of material health impairment from exposure to lead, then the employee must be removed from exposure to lead at or above $30 \mu\text{g}/\text{m}^3$. Alternatively, if the examining physician recommends special protective measures for an employee (e.g., use of a powered air purifying respirator) or recommends limitations on an employee's exposure to lead, then the employer must implement these recommendations.

Recommendations may be more stringent than the specific provisions of the standard. The examining physician, therefore, is given broad flexibility to tailor special protective procedures to the needs of individual employees. This flexibility extends to the evaluation and management of pregnant workers and male and female workers who are planning to raise children. Based on the history, physical examination, and laboratory studies, the physician might recommend special protective measures or medical removal for an employee who is pregnant or who is planning to conceive a child when, in the physician's judgment, continued exposure to lead at the current job would pose a significant risk. The return of the employee to his or her former job status, or the removal of special protections or limitations, depends upon the examining physician determining that the employee is no longer at increased risk of material impairment or that special measures are no longer needed.

During the period of any form of special protection or removal, the employer must maintain the worker's earnings, seniority, and other employment rights and benefits (as though the worker had not been removed) for a period of up to 18 months or for as long as the job the employee was removed from lasts if less than 18 months. This economic protection will maximize meaningful worker participation in the medical surveillance program, and is appropriate as part of the employer's overall obligation to provide a safe and healthful workplace. The provisions of MRP benefits during the employee's removal period may, however, be conditioned upon participation in medical surveillance.

The lead standard provides for a multiple physician review in cases where the employee wishes a second opinion concerning potential lead poisoning or toxicity. If an employee wishes a second opinion, he or she can make an appointment with a physician of his or her choice. This second physician will review the findings, recommendations or determinations of the first physician and conduct any examinations, consultations or tests deemed necessary in an attempt to make a final medical determination. If the first and second physicians do not agree in their assessment they must try to resolve their differences. If they cannot reach an agreement then they must designate a third physician to resolve the dispute.

The employer must provide examining and consulting physicians with the following specific information: A copy of the lead regulations and all appendices, a description of the employee's duties as related to exposure, the exposure level

or anticipated level to lead and any other toxic substances (if applicable), a description of personal protective equipment used, blood lead levels, and all prior written medical opinions regarding the employee in the employer's possession or control. The employer must also obtain from the physician and provide the employee with a written medical opinion containing blood lead levels, the physician's opinion as to whether the employee is at risk of material impairment to health, any recommended protective measures for the employee if further exposure is permitted, as well as any recommended limitations upon an employee's use of respirators.

Employers must instruct each physician not to reveal to the employer in writing or in any other way his or her findings, laboratory results, or diagnoses which are felt to be unrelated to occupational lead exposure. They must also instruct each physician to advise the employee of any occupationally or non-occupationally related medical condition requiring further treatment or evaluation.

The standard provides for the use of respirators where engineering and other primary controls are not effective. However, the use of respirator protection shall not be used in lieu of temporary medical removal due to elevated blood lead levels or findings that an employee is at risk of material health impairment. This is based on the numerous inadequacies of respirators including skin rash where the facepiece makes contact with the skin, unacceptable stress to breathing in some workers with underlying cardiopulmonary impairment, difficulty in providing adequate fit, the tendency for respirators to create additional hazards by interfering with vision, hearing, and mobility, and the difficulties of assuring the maximum effectiveness of a complicated work practice program involving respirators. Respirators do, however, serve a useful function where engineering and work practice controls are inadequate by providing supplementary, interim, or short-term protection, provided they are properly selected for the environment in which the employee will be working, properly fitted to the employee, maintained and cleaned periodically, and worn by the employee when required.

In its interim final standard on occupational exposure to inorganic lead in the construction industry, OSHA has prohibited prophylactic chelation. Diagnostic and therapeutic chelation are permitted only under the supervision of a licensed physician with appropriate medical monitoring in an acceptable clinical setting. The decision to initiate chelation therapy must be made on an individual basis and take into account the severity of symptoms felt to be a result of lead toxicity along with blood lead levels, ZPP levels,

and other laboratory tests as appropriate. EDTA and penicillamine which are the primary chelating agents used in the therapy of occupational lead poisoning have significant potential side effects and their use must be justified on the basis of expected benefits to the worker. Unless frank and severe symptoms are present, therapeutic chelation is not recommended, given the opportunity to remove a worker from exposure and allow the body to naturally excrete accumulated lead. As a diagnostic aid, the chelation mobilization test using CA-EDTA has limited applicability. According to some investigators, the test can differentiate between lead-induced and other nephropathies. The test may also provide an estimation of the mobile fraction of the total body lead burden.

Employers are required to assure that accurate records are maintained on exposure assessment, including environmental monitoring, medical surveillance, and medical removal for each employee. Exposure assessment records must be kept for at least 30 years. Medical surveillance records must be kept for the duration of employment plus 30 years except in cases where the employment was less than one year. If duration of employment is less than one year, the employer need not retain this record beyond the term of employment if the record is provided to the employee upon termination of employment. Medical removal records also must be maintained for the duration of employment. All records required under the standard must be made available upon request to the Assistant Secretary of Labor for Occupational Safety and Health and the Director of the National Institute for Occupational Safety and Health. Employers must also make environmental and biological monitoring and medical removal records available to affected employees and to former employees or their authorized employee representatives. Employees or their specifically designated representatives have access to their entire medical surveillance records.

In addition, the standard requires that the employer inform all workers exposed to lead at or above $30 \mu\text{g}/\text{m}^3$ of the provisions of the standard and all its appendices, the purpose and description of medical surveillance and provisions for medical removal protection if temporary removal is required. An understanding of the potential health effects of lead exposure by all exposed employees along with full understanding of their rights under the lead standard is essential for an effective monitoring program.

II. Adverse Health Effects of Inorganic Lead

Although the toxicity of lead has been known for 2,000 years, the knowledge of the complex relationship between lead exposure and human

response is still being refined. Significant research into the toxic properties of lead continues throughout the world, and it should be anticipated that our understanding of thresholds of effects and margins of safety will be improved in future years. The provisions of the lead standard are founded on two prime medical judgments: First, the prevention of adverse health effects from exposure to lead throughout a working lifetime requires that worker blood lead levels be maintained at or below 40 $\mu\text{g}/\text{dl}$ and second, the blood lead levels of workers, male or female, who intend to parent in the near future should be maintained below 30 $\mu\text{g}/\text{dl}$ to minimize adverse reproductive health effects to the parents and developing fetus. The adverse effects of lead on reproduction are being actively researched and OSHA encourages the physician to remain abreast of recent developments in the area to best advise pregnant workers or workers planning to conceive children.

The spectrum of health effects caused by lead exposure can be subdivided into five developmental stages: Normal, physiological changes of uncertain significance, pathophysiological changes, overt symptoms (morbidity), and mortality. Within this process there are no sharp distinctions, but rather a continuum of effects. Boundaries between categories overlap due to the wide variation of individual responses and exposures in the working population. OSHA's development of the lead standard focused on pathophysiological changes as well as later stages of disease.

1. Heme Synthesis Inhibition. The earliest demonstrated effect of lead involves its ability to inhibit at least two enzymes of the heme synthesis pathway at very low blood levels. Inhibition of delta aminolevulinic acid dehydrase (ALA-D) which catalyzes the conversion of delta-aminolevulinic acid (ALA) to protoporphyrin is observed at a blood lead level below 20 $\mu\text{g}/\text{dl}$. At a blood lead level of 40 $\mu\text{g}/\text{dl}$, more than 20% of the population would have 70% inhibition of ALA-D. There is an exponential increase in ALA excretion at blood lead levels greater than 40 $\mu\text{g}/\text{dl}$.

Another enzyme, ferrochelatase, is also inhibited at low blood lead levels. Inhibition of ferrochelatase leads to increased free erythrocyte protoporphyrin (FEP) in the blood which can then bind to zinc to yield zinc protoporphyrin. At a blood lead level of 50 $\mu\text{g}/\text{dl}$ or greater, nearly 100% of the population will have an increase in FEP. There is also an exponential relationship between blood lead levels greater than 40 $\mu\text{g}/\text{dl}$ and the associated ZPP level, which has led to the development of the ZPP screening test for lead exposure.

While the significance of these effects is subject to debate, it is OSHA's position that these enzyme disturbances are early stages of a disease process which may eventually result in the clinical symptoms of lead poisoning. Whether or not the effects do progress to the later stages of clinical disease, disruption of these enzyme processes over a working lifetime is considered to be a material impairment of health.

One the eventual results of lead-induced inhibition of enzymes in the heme synthesis pathway is anemia which can be asymptomatic if mild but associated with a wide array of symptoms including dizziness, fatigue, and tachycardia when more severe. Studies have indicated that lead levels as low as 50 $\mu\text{g}/\text{dl}$ can be associated with a definite decreased hemoglobin, although most cases of lead-induced anemia, as well as shortened red-cell survival times, occur at lead levels exceeding 80 $\mu\text{g}/\text{dl}$. Inhibited hemoglobin synthesis is more common in chronic cases whereas shortened erythrocyte life span is more common in acute cases.

In lead-induced anemias, there is usually a reticulocytosis along with the presence of basophilic stippling, and ringed sideroblasts, although none of the above are pathognomonic for lead-induced anemia.

2. Neurological Effects. Inorganic lead has been found to have toxic effects on both the central and peripheral nervous systems. The earliest stages of lead-induced central nervous system effects first manifest themselves in the form of behavioral disturbances and central nervous system symptoms including irritability, restlessness, insomnia and other sleep disturbances, fatigue, vertigo, headache, poor memory, tremor, depression, and apathy. With more severe exposure, symptoms can progress to drowsiness, stupor, hallucinations, delirium, convulsions and coma.

The most severe and acute form of lead poisoning which usually follows ingestion or inhalation of large amounts of lead is acute encephalopathy which may arise precipitously with the onset of intractable seizures, coma, cardiorespiratory arrest, and death within 48 hours.

While there is disagreement about what exposure levels are needed to produce the earliest symptoms, most experts agree that symptoms definitely can occur at blood lead levels of 60 $\mu\text{g}/\text{dl}$ whole blood and therefore recommend a 40 $\mu\text{g}/\text{dl}$ maximum. The central nervous system effects frequently are not

reversible following discontinued exposure or chelation therapy and when improvement does occur, it is almost always only partial.

The peripheral neuropathy resulting from lead exposure characteristically involves only motor function with minimal sensory damage and has a marked predilection for the extensor muscles of the most active extremity. The peripheral neuropathy can occur with varying degrees of severity. The earliest and mildest form which can be detected in workers with blood lead levels as low as 50 µg/dl is manifested by slowing of motor nerve conduction velocity often without clinical symptoms. With progression of the neuropathy there is development of painless extensor muscle weakness usually involving the extensor muscles of the fingers and hand in the most active upper extremity, followed in severe cases by wrist drop or, much less commonly, foot drop.

In addition to slowing of nerve conduction, electromyographical studies in patients with blood lead levels greater than 50 µg/dl have demonstrated a decrease in the number of acting motor unit potentials, an increase in the duration of motor unit potentials, and spontaneous pathological activity including fibrillations and fasciculations. Whether these effects occur at levels of 40 µg/dl is undetermined.

While the peripheral neuropathies can occasionally be reversed with therapy, again such recovery is not assured particularly in the more severe neuropathies and often improvement is only partial. The lack of reversibility is felt to be due in part to segmental demyelination.

3. Gastrointestinal. Lead may also affect the gastrointestinal system producing abdominal colic or diffuse abdominal pain, constipation, obstipation, diarrhea, anorexia, nausea and vomiting. Lead colic rarely develops at blood lead levels below 80 µg/dl.

4. Renal. Renal toxicity represents one of the most serious health effects of lead poisoning. In the early stages of disease nuclear inclusion bodies can frequently be identified in proximal renal tubular cells. Renal function remains normal and the changes in this stage are probably reversible. With more advanced disease there is progressive interstitial fibrosis and impaired renal function. Eventually extensive interstitial fibrosis ensues with sclerotic glomeruli and dilated and atrophied proximal tubules; all represent end stage kidney disease. Azotemia can be progressive, eventually resulting in frank uremia necessitating dialysis. There is occasionally associated hypertension and hyperuricemia with or without gout.

Early kidney disease is difficult to detect. The urinalysis is normal in early lead nephropathy and the blood urea nitrogen and serum creatinine increase only when two-thirds of kidney function is lost. Measurement of creatinine clearance can often detect earlier disease as can other methods of measurement of glomerular filtration rate. An abnormal Ca-EDTA mobilization test has been used to differentiate between lead-induced and other nephropathies, but this procedure is not widely accepted. A form of Fanconi syndrome with aminoaciduria, glycosuria, and hyperphosphaturia indicating severe injury to the proximal renal tubules is occasionally seen in children.

5. Reproductive effects. Exposure to lead can have serious effects on reproductive function in both males and females. In male workers exposed to lead there can be a decrease in sexual drive, impotence, decreased ability to produce healthy sperm, and sterility. Malformed sperm (teratospermia), decreased number of sperm (hypospermia), and sperm with decreased motility (asthenospermia) can all occur. Teratospermia has been noted at mean blood lead levels of 53 µg/dl and hypospermia and asthenospermia at 41 µg/dl. Furthermore, there appears to be a dose-response relationship for teratospermia in lead exposed workers.

Women exposed to lead may experience menstrual disturbances including dysmenorrhea, menorrhagia and amenorrhea. Following exposure to lead, women have a higher frequency of sterility, premature births, spontaneous miscarriages, and stillbirths.

Germ cells can be affected by lead and cause genetic damage in the egg or sperm cells before conception and result in failure to implant, miscarriage, stillbirth, or birth defects.

Infants of mothers with lead poisoning have a higher mortality during the first year and suffer from lowered birth weights, slower growth, and nervous system disorders.

Lead can pass through the placental barrier and lead levels in the mother's blood are comparable to concentrations of lead in the umbilical cord at birth. Transplacental passage becomes detectable at 12-14 weeks of gestation and increases until birth.

There is little direct data on damage to the fetus from exposure to lead but it is generally assumed that the fetus and newborn would be at least as susceptible to neurological damage as young children. Blood lead levels of 50-60 µg/dl in children can cause significant neurobehavioral impairments and there is evidence of hyperactivity at blood levels as low as 25 µg/dl. Given the overall body of literature concerning the adverse health effects of lead in

children, OSHA feels that the blood lead level in children should be maintained below 30 µg/dl with a population mean of 15 µg/dl. Blood lead levels in the fetus and newborn likewise should not exceed 30 µg/dl.

Because of lead's ability to pass through the placental barrier and also because of the demonstrated adverse effects of lead on reproductive function in both the male and female as well as the risk of genetic damage of lead on both the ovum and sperm, OSHA recommends a 30 µg/dl maximum permissible blood lead level in both males and females who wish to bear children.

6. Other toxic effects. Debate and research continue on the effects of lead on the human body. Hypertension has frequently been noted in occupationally exposed individuals although it is difficult to assess whether this is due to lead's adverse effects on the kidney or if some other mechanism is involved. Vascular and electrocardiographic changes have been detected but have not been well characterized. Lead is thought to impair thyroid function and interfere with the pituitary-adrenal axis, but again these effects have not been well defined.

III. Medical Evaluation

The most important principle in evaluating a worker for any occupational disease including lead poisoning is a high index of suspicion on the part of the examining physician. As discussed in Section 2, lead can affect numerous organ systems and produce a wide array of signs and symptoms, most of which are non-specific and subtle in nature at least in the early stages of disease. Unless serious concern for lead toxicity is present, many of the early clues to diagnosis may easily be overlooked.

The crucial initial step in the medical evaluation is recognizing that a worker's employment can result in exposure to lead. The worker will frequently be able to define exposures to lead and lead containing materials but often will not volunteer this information unless specifically asked. In other situations the worker may not know of any exposures to lead but the suspicion might be raised on the part of the physician because of the industry or occupation of the worker. Potential occupational exposure to lead and its compounds occur in many occupations in the construction industry, including demolition and salvaging operations, removal or encapsulation of materials containing lead, construction, alteration, repair or renovation of structures containing lead, transportation, disposal, storage or containment of lead or lead-containing materials on construction sites, and maintenance operations associated with construction activities.

Once the possibility for lead exposure is raised, the focus can then be directed toward eliciting information from the medical history, physical exam, and finally from laboratory data to evaluate the worker for potential lead toxicity.

A complete and detailed work history is important in the initial evaluation. A listing of all previous employment with information on job description, exposure to fumes or dust, known exposures to lead or other toxic substances, a description of any personal protective equipment used, and previous medical surveillance should all be included in the worker's record. Where exposure to lead is suspected, information concerning on-the-job personal hygiene, smoking or eating habits in work areas, laundry procedures, and use of any protective clothing or respiratory protection equipment should be noted. A complete work history is essential in the medical evaluation of a worker with suspected lead toxicity, especially when long term effects such as neurotoxicity and nephrotoxicity are considered.

The medical history is also of fundamental importance and should include a listing of all past and current medical conditions, current medications including proprietary drug intake, previous surgeries and hospitalizations, allergies, smoking history, alcohol consumption, and also non-occupational lead exposures such as hobbies (hunting, riflery). Also known childhood exposures should be elicited. Any previous history of hematological, neurological, gastrointestinal, renal, psychological, gynecological, genetic, or reproductive problems should be specifically noted.

A careful and complete review of systems must be performed to assess both recognized complaints and subtle or slowly acquired symptoms which the worker might not appreciate as being significant. The review of symptoms should include the following:

- 1. General** -- weight loss, fatigue, decreased appetite.
- 2. Head, Eyes, Ears, Nose, Throat (HEENT)** -- headaches, visual disturbances or decreased visual acuity, hearing deficits or tinnitus, pigmentation of the oral mucosa, or metallic taste in mouth.
- 3. Cardio-pulmonary** -- shortness of breath, cough, chest pains, palpitations, or orthopnea.
- 4. Gastrointestinal** -- nausea, vomiting, heart-burn, abdominal pain, constipation or diarrhea.

5. Neurologic -- irritability, insomnia, weakness (fatigue), dizziness, loss of memory, confusion, hallucinations, incoordination, ataxia, decreased strength in hands or feet, disturbances in gait, difficulty in climbing stairs, or seizures.

6. Hematologic -- pallor, easy fatigability, abnormal blood loss, melena.

7. Reproductive (male and female and spouse where relevant) -- history of infertility, impotence, loss of libido, abnormal menstrual periods, history of miscarriages, stillbirths, or children with birth defects.

8. Musculo-skeletal -- muscle and joint pains.

The physical examination should emphasize the neurological, gastrointestinal, and cardiovascular systems. The worker's weight and blood pressure should be recorded and the oral mucosa checked for pigmentation characteristic of a possible Burtonian or lead line on the gingiva. It should be noted, however, that the lead line may not be present even in severe lead poisoning if good oral hygiene is practiced.

The presence of pallor on skin examination may indicate an anemia which, if severe, might also be associated with a tachycardia. If an anemia is suspected, an active search for blood loss should be undertaken including potential blood loss through the gastrointestinal tract.

A complete neurological examination should include an adequate mental status evaluation including a search for behavioral and psychological disturbances, memory testing, evaluation for irritability, insomnia, hallucinations, and mental clouding. Gait and coordination should be examined along with close observation for tremor. A detailed evaluation of peripheral nerve function including careful sensory and motor function testing is warranted. Strength testing particularly of extensor muscle groups of all extremities is of fundamental importance.

Cranial nerve evaluation should also be included in the routine examination.

The abdominal examination should include auscultation for bowel sounds and abdominal bruits and palpation for organomegaly, masses, and diffuse abdominal tenderness.

Cardiovascular examination should evaluate possible early signs of congestive heart failure. Pulmonary status should be addressed particularly if respirator protection is contemplated.

As part of the medical evaluation, the interim lead standard requires the following laboratory studies:

1. Blood lead level

2. Hemoglobin and hematocrit determinations, red cell indices, and examination of the peripheral blood smear to evaluate red blood cell morphology

3. Blood urea nitrogen

4. Serum creatinine

5. Routine urinalysis with microscopic examination

6. A zinc protoporphyrin level.

In addition to the above, the physician is authorized to order any further laboratory or other tests which he or she deems necessary in accordance with sound medical practice. The evaluation must also include pregnancy testing or laboratory evaluation of male fertility if requested by the employee. Additional tests which are probably not warranted on a routine basis but may be appropriate when blood lead and ZPP levels are equivocal include delta aminolevulinic acid and coproporphyrin concentrations in the urine, and dark-field illumination for detection of basophilic stippling in red blood cells.

If an anemia is detected further studies including a careful examination of the peripheral smear, reticulocyte count, stool for occult blood, serum iron, total iron binding capacity, bilirubin, and, if appropriate, vitamin B12 and folate may be of value in attempting to identify the cause of the anemia.

If a peripheral neuropathy is suspected, nerve conduction studies are warranted both for diagnosis and as a basis to monitor any therapy.

If renal disease is questioned, a 24 hour urine collection for creatinine clearance, protein, and electrolytes may be indicated. Elevated uric acid levels may result from lead-induced renal disease and a serum uric acid level might be performed.

An electrocardiogram and chest x-ray may be obtained as deemed appropriate.

Sophisticated and highly specialized testing should not be done routinely and where indicated should be under the direction of a specialist.

IV. Laboratory Evaluation

The blood lead level at present remains the single most important test to monitor lead exposure and is the test used in the medical surveillance program under the lead standard to guide employee medical removal. The ZPP has several advantages over the blood lead level. Because of its relatively recent development and the lack of extensive data concerning its interpretation, the ZPP currently remains an ancillary test.

This section will discuss the blood lead level and ZPP in detail and will outline their relative advantages and disadvantages. Other blood tests currently available to evaluate lead exposure will also be reviewed.

The blood lead level is a good index of current or recent lead absorption when there is no anemia present and when the worker has not taken any chelating agents. However, blood lead levels along with urinary lead levels do not necessarily indicate the total body burden of lead and are not adequate measures of past exposure. One reason for this is that lead has a high affinity for bone and up to 90% of the body's total lead is deposited there. A very important component of the total lead body burden is lead in soft tissue (liver, kidney, and brain). This fraction of the lead body burden, the biologically active lead, is not entirely reflected by blood lead levels since it is a function of the dynamics of lead absorption, distribution, deposition in bone and excretion. Following discontinuation of exposure to lead, the excess body burden is only slowly mobilized from bone and other relatively stable body stores and excreted. Consequently, a high blood lead level may only represent recent heavy exposure to lead without a significant total body excess and likewise a low blood lead level does not exclude an elevated total body burden of lead.

Also due to its correlation with recent exposures, the blood lead level may vary considerably over short time intervals.

To minimize laboratory error and erroneous results due to contamination, blood specimens must be carefully collected after thorough cleaning of the skin with appropriate methods using lead-free blood containers and analyzed by a reliable laboratory. Under the standard, samples must be analyzed in laboratories which are approved by OSHA. Analysis is to be made using atomic absorption spectrophotometry, anodic stripping voltammetry or any method which meets the accuracy requirements set forth by the standard.

The determination of lead in urine is generally considered a less reliable monitoring technique than analysis of whole blood primarily due to

individual variability in urinary excretion capacity as well as the technical difficulty of obtaining accurate 24 hour urine collections. In addition, workers with renal insufficiency, whether due to lead or some other cause, may have decreased lead clearance and consequently urine lead levels may underestimate the true lead burden. Therefore, urine lead levels should not be used as a routine test.

The zinc protoporphyrin test, unlike the blood lead determination, measures an adverse metabolic effect of lead and as such is a better indicator of lead toxicity than the level of blood lead itself. The level of ZPP reflects lead absorption over the preceding 3 to 4 months, and therefore is a better indicator of lead body burden. The ZPP requires more time than the blood lead to read significantly elevated levels; the return to normal after discontinuing lead exposure is also slower. Furthermore, the ZPP test is simpler, faster, and less expensive to perform and no contamination is possible. Many investigators believe it is the most reliable means of monitoring chronic lead absorption.

Zinc protoporphyrin results from the inhibition of the enzyme ferrochelatase which catalyzes the insertion of an iron molecule into the protoporphyrin molecule, which then becomes heme. If iron is not inserted into the molecule then zinc, having a greater affinity for protoporphyrin, takes the place of the iron, forming ZPP.

An elevation in the level of circulating ZPP may occur at blood lead levels as low as 20-30 $\mu\text{g}/\text{dl}$ in some workers. Once the blood lead level has reached 40 $\mu\text{g}/\text{dl}$ there is more marked rise in the ZPP value from its normal range of less than 100 $\mu\text{g}/\text{dl}$ to 100 $\mu\text{g}/\text{dl}$. Increases in blood lead levels beyond 40 $\mu\text{g}/100\text{ g}$ are associated with exponential increases in ZPP.

Whereas blood lead levels fluctuate over short time spans, ZPP levels remain relatively stable. ZPP is measured directly in red blood cells and is present for the cell's entire 120 day life-span. Therefore, the ZPP level in blood reflects the average ZPP production over the previous 3-4 months and consequently the average lead exposure during that time interval.

It is recommended that a hematocrit be determined whenever a confirmed ZPP of 50 $\mu\text{g}/100\text{ ml}$ whole blood is obtained to rule out a significant underlying anemia. If the ZPP is in excess of 100 $\mu\text{g}/100\text{ ml}$ and not associated with abnormal elevations in blood lead levels, the laboratory should be checked to be sure that blood leads were determined using atomic absorption spectrophotometry anodic stripping voltammetry, or any method which meets the accuracy requirements set forth by the standard

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by an OSHA approved laboratory which is experienced in lead level determinations. Repeat periodic blood lead studies should be obtained in all individuals with elevated ZPP levels to be certain that an associated elevated blood lead level has not been missed due to transient fluctuations in blood leads.

ZPP has a characteristic fluorescence spectrum with a peak at 594 nm which is detectable with a hematofluorimeter. The hematofluorimeter is accurate and portable and can provide on-site, instantaneous results for workers who can be frequently tested via a finger prick.

However, careful attention must be given to calibration and quality control procedures. Limited data on blood lead-ZPP correlations and the ZPP levels which are associated with the adverse health effects discussed in Section 2 are the major limitations of the test. Also it is difficult to correlate ZPP levels with environmental exposure and there is some variation of response with age and sex. Nevertheless, the ZPP promises to be an important diagnostic test for the early detection of lead toxicity and its value will increase as more data is collected regarding its relationship to other manifestations of lead poisoning.

Levels of delta-aminolevulinic acid (ALA) in the urine are also used as a measure of lead exposure. Increasing concentrations of ALA are believed to result from the inhibition of the enzyme delta-aminolevulinic acid dehydrase (ALA-D). Although the test is relatively easy to perform, inexpensive, and rapid, the disadvantages include variability in results, the necessity to collect a complete 24 hour urine sample which has a specific gravity greater than 1.010, and also the fact that ALA decomposes in the presence of light.

The pattern of porphyrin excretion in the urine can also be helpful in identifying lead intoxication. With lead poisoning, the urine concentrations of coproporphyrins I and II, porphobilinogen and uroporphyrin I rise. The most important increase, however, is that of coproporphyrin III; levels may exceed 5,000 µg/l in the urine in lead poisoned

individuals, but its correlation with blood lead levels and ZPP are not as good as those of ALA. Increases in urinary porphyrins are not diagnostic of lead toxicity and may be seen in porphyria, some liver diseases, and in patients with high reticulocyte counts.

Summary. The Occupational Safety and Health Administration's interim standard for inorganic lead in the construction industry places significant emphasis on the medical surveillance of all workers exposed to levels of inorganic lead above 30 µg/m³ TWA. The physician has a fundamental role in this surveillance program, and in the operation of the medical removal protection program.

Even with adequate worker education on the adverse health effects of lead and appropriate training in work practices, personal hygiene and other control measures, the physician has a primary responsibility for evaluating potential lead toxicity in the worker. It is only through a careful and detailed medical and work history, a complete physical examination and appropriate laboratory testing that an accurate assessment can be made. Many of the adverse health effects of lead toxicity are either irreversible or only partially reversible and therefore early detection of disease is very important.

This document outlines the medical monitoring program as defined by the occupational safety and health standard for inorganic lead. It reviews the adverse health effects of lead poisoning and describes the important elements of the history and physical examinations as they relate to these adverse effects. Finally, the appropriate laboratory testing for evaluating lead exposure and toxicity is presented.

It is hoped that this review and discussion will give the physician a better understanding of the OSHA standard with the ultimate goal of protecting the health and well-being of the worker exposed to lead under his or her care.

Stat. Auth.: ORS 654.025(2) and ORS 656.726(3).
Hist: OR-OSHA Admin. Order 16-1993, f. 11/1/93, ef. 11/1/93 (Lead).

APPENDIX D TO §1926.62 – QUALITATIVE AND QUANTITATIVE FIT TEST PROTOCOLS

I. Fit Test Protocols

A. General: The employer shall include the following provisions in the fit test procedures. These provisions apply to both qualitative fit testing (QLFT) and quantitative fit testing (QNFT) permissible for compliance with paragraph (f)(3)(ii) of § 1926.62. All testing is to be conducted annually.

1. The test subject shall be allowed to pick the most comfortable respirator from a selection including respirators of various sizes from different manufacturers. The selection shall include at least three sizes of elastomeric facepieces of the type of respirator that is to be tested, i.e., three sizes of half mask; or three sizes of full facepiece. Respirators of each size must be provided from at least two manufacturers.

2. Prior to the selection process, the test subject shall be shown how to put on a respirator, how it should be positioned on the face, how to set strap tension and how to determine a comfortable fit. A mirror shall be available to assist the subject in evaluating the fit and positioning the respirator. This instruction may not constitute the subject's formal training on respirator use, as it is only a review.

3. The test subject shall be informed that he/she is being asked to select the respirator which provides the most comfortable fit. Each respirator represents a different size and shape, and if fitted, maintained and used properly, will provide adequate protection.

4. The test subject shall be instructed to hold each facepiece up to the face and eliminate those which obviously do not give a comfortable fit.

5. The more comfortable facepieces are noted; the most comfortable mask is donned and worn at least five minutes to assess comfort. Assistance in assessing comfort can be given by discussing the points in item 6 below. If the test subject is not familiar with using a particular respirator, the test subject shall be directed to don the mask several times and to adjust the straps each time to become adept at setting proper tension on the straps.

6. Assessment of comfort shall include reviewing the following points with the test subject and allowing the test subject adequate time to determine the comfort of the respirator:

(a) position of the mask on the nose;

(b) room for eye protection;

(c) room to talk; and

(d) position of mask on face and cheeks.

7. The following criteria shall be used to help determine the adequacy of the respirator fit:

(a) chin properly placed;

(b) adequate strap tension, not overly tightened;

(c) fit across nose bridge;

(d) respirator of proper size to span distance from nose to chin;

(e) tendency of respirator to slip; and

(f) self-observation in mirror to evaluate fit and respirator position.

8. The test subject shall conduct the negative and positive pressure fit checks as described below or in ANSI Z88.2-1980. Before conducting the negative or positive pressure test, the subject shall be told to seat the mask on the face by moving the head from side-to-side and up and down slowly while taking in a few slow deep breaths. Another facepiece shall be selected and retested if the test subject fails the fit check tests.

(a) Positive pressure check. Close off the exhalation valve and exhale gently into the facepiece. The face fit is considered satisfactory if a slight positive pressure can be built up inside the facepiece without any evidence of outward leakage of air at the seal. For most respirators this method of leak testing requires the wearer to first remove the exhalation valve cover before closing off the exhalation valve and then carefully replacing it after the test.

(b) Negative pressure check. Close off the inlet opening of the canister or cartridge(s) by covering with the palm of the hand(s) or by replacing the filter seal(s), inhale gently so that the facepiece collapses slightly, and hold the breath for ten seconds. If the facepiece remains in its slightly collapsed condition and no inward leakage of air is detected, the tightness of the respirator is considered satisfactory.

9. The test shall not be conducted if there is any hair growth between the skin and the facepiece sealing surface, such as stubble

beard growth, beard, or long sideburns which cross the respirator sealing surface. Any type of apparel which interferes with a satisfactory fit shall be altered or removed.

10. If a test subject exhibits difficulty in breathing during the tests, she or he shall be referred to a physician to determine whether the test subject can wear a respirator while performing her or his duties.

11. If at any time within the first two week of use the respirator becomes uncomfortable, the test subject shall be given the opportunity to select a different facepiece and to be retested.

12. The employer shall maintain a record of the fit test administered to an employee. The record shall contain at least the following information:

- (a) name of employee;
- (b) type of respirator;
- (c) brand, size of respirator;
- (d) date of test;
- (e) where QNFT is used: the fit factor, strip chart recording or other recording of the results of the test. The record shall be maintained until the next fit test is administered.

13. **Exercise regimen.** Prior to the commencement of the fit test, the test subject shall be given a description of the fit test and the test subject's responsibilities during the test procedure. The description of the process shall include a description of the test exercises that the subject will be performing. The respirator to be tested shall be worn for at least 5 minutes before the start of the fit test.

14. **Test Exercises.** The test subject shall perform exercises, in the test environment, in the manner described below:

- (a) **Normal breathing.** In a normal standing position, without talking, the subject shall breathe normally.
- (b) **Deep breathing.** In a normal standing position, the subject shall breathe slowly and deeply, taking caution so as to not hyperventilate.
- (c) **Turning head side to side.** Standing in place, the subject shall slowly turn his/her head from side to side between the extreme positions on each side. The head shall be held at each extreme momentarily so the subject can inhale at each side.

(d) **Moving head up and down.** Standing in place, the subject shall slowly move his/her head up and down. The subject shall be instructed to inhale in the up position (i.e., when looking toward the ceiling).

(e) **Talking.** The subject shall talk out loud slowly and loud enough so as to be heard clearly by the test conductor. The subject can read from a prepared text such as the Rainbow Passage (see below), count backward from 100, or recite a memorized poem or song.

Rainbow Passage

When the sunlight strikes raindrops in the air, they act like a prism and form a rainbow. The rainbow is a division of white light into many beautiful colors. These take the shape of a long round arch, with its path high above, and its two ends apparently beyond the horizon. There is, according to legend, a boiling pot of gold at one end. People look, but no one ever finds it. When a man looks for something beyond reach, his friends say he is looking for the pot of gold at the end of the rainbow.

(f) **Grimace.** The test subject shall grimace by smiling or frowning.

(g) **Bending over.** The test subject shall bend at the waist as if he/she were to touch his/her toes. Jogging in place shall be substituted for this exercise in those test environments such as shroud type QNFT units which prohibit bending at the waist.

(h) **Normal breathing.** Same as exercise 1.

Each test exercise shall be performed for one minute except for the grimace exercise which shall be performed for 15 seconds. The test subject shall be questioned by the test conductor regarding the comfort of the respirator upon completion of the protocol. If it has become uncomfortable, another model of respirator shall be tried.

B. Qualitative Fit Test (QLFT) Protocols.

1. General.

(a) The employer shall assign specific individuals who shall assume full responsibility for implementing the respirator qualitative fit test program.

(b) The employer shall ensure that persons administering QLFT are able to prepare test solutions, calibrate equipment and perform

tests properly, recognize invalid tests, and assure that test equipment is in proper working order.

(c) The employer shall assure that QLFT equipment is kept clean and well maintained so as to operate at the parameters for which it was designed.

2. Isoamyl Acetate Protocol.

(a) **Odor threshold screening.** The odor threshold screening test, performed without wearing a respirator, is intended to determine if the individual tested can detect the odor of isoamyl acetate.

(1) Three 1 liter glass jars with metal lids are required.

(2) Odor free water (e.g., distilled or spring water) at approximately 25 degrees C shall be used for the solutions.

(3) The isoamyl acetate (IAA) (also known as isopentyl acetate) stock solution is prepared by adding 1 cc of pure IAA to 800 cc of odor free water in a 1 liter jar and shaking for 30 seconds. A new solution shall be prepared at least weekly.

(4) The screening test shall be conducted in a room separate from the room used for actual fit testing. The two rooms shall be well ventilated but shall not be connected to the same recirculating ventilation system.

(5) The odor test solution is prepared in a second jar by placing 0.4 cc of the stock solution into 500 cc of odor free water using a clean dropper or pipette. The solution shall be shaken for 30 seconds and allowed to stand for two to three minutes so that the IAA concentration above the liquid may reach equilibrium. This solution shall be used for only one day.

(6) A test blank shall be prepared in a third jar by adding 500 cc of odor free water.

(7) The odor test and test blank jars shall be labeled 1 and 2 for jar identification. Labels shall be placed on the lids so they can be periodically peeled, dried off and switched to maintain the integrity of the test.

(8) The following instruction shall be typed on a card and placed on the table in front of the two test jars (i.e., 1 and 2): "The purpose of this test is to determine if you can smell banana oil at a low con-

centration. The two bottles in front of you contain water. One of these bottles also contains a small amount of banana oil. Be sure the covers are on tight, then shake each bottle for two seconds. Unscrew the lid of each bottle, one at a time, and sniff at the mouth of the bottle. Indicate to the test conductor which bottle contains banana oil."

(9) The mixtures used in the IAA odor detection test shall be prepared in an area separate from where the test is performed, in order to prevent olfactory fatigue in the subject.

(10) If the test subject is unable to correctly identify the jar containing the odor test solution, the IAA qualitative fit test shall not be performed.

(11) If the test subject correctly identifies the jar containing the odor test solution, the test subject may proceed to respirator selection and fit testing.

(b) Isoamyl acetate fit test.

(1) The fit test chamber shall be similar to a clear 55-gallon drum liner suspended inverted over a 2-foot diameter frame so that the top of the chamber is about 6 inches above the test subject's head. The inside top center of the chamber shall have a small hook attached.

(2) Each respirator used for the fitting and fit testing shall be equipped with organic vapor cartridges or offer protection against organic vapors. The cartridges or masks shall be changed at least weekly.

(3) After selecting, donning, and properly adjusting a respirator, the test subject shall wear it to the fit testing room. This room shall be separate from the room used for odor threshold screening and respirator selection, and shall be well ventilated, as by an exhaust fan or lab hood, to prevent general room contamination.

(4) A copy of the test exercises and any prepared text from which the subject is to read shall be taped to the inside of the test chamber.

(5) Upon entering the test chamber, the test subject shall be given a 6-inch by 5-inch piece of paper towel, or other porous, absorbent, single-ply material, folded in half and wetted with 0.75 cc of pure IAA. The test subject shall hang the wet towel on the hook at the top of the chamber.

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(6) Allow two minutes for the IAA test concentration to stabilize before starting the fit test exercises. This would be an appropriate time to talk with the test subject; to explain the fit test, the importance of his/her cooperation, and the purpose for the head exercises; or to demonstrate some of the exercises.

(7) If at any time during the test, the subject detects the banana like odor of IAA, the test has failed. The subject shall quickly exit from the test chamber and leave the test area to avoid olfactory fatigue.

(8) If the test has failed, the subject shall return to the selection room and remove the respirator, repeat the odor sensitivity test, select and put on another respirator, return to the test chamber and again begin the procedure described in (I)(B)(2)(b)(1) through (7) of this appendix. The process continues until a respirator that fits well has been found. Should the odor sensitivity test be failed, the subject shall wait about 5 minutes before retesting. Odor sensitivity will usually have returned by this time.

(9) When a respirator is found that passes the test, its efficiency shall be demonstrated for the subject by having the subject break the face seal and take a breath before exiting the chamber.

(10) When the test subject leaves the chamber, the subject shall remove the saturated towel and return it to the person conducting the test. To keep the test area from becoming contaminated, the used towels shall be kept in a self sealing bag so there is no significant IAA concentration build-up in the test chamber during subsequent tests.

3. Saccharin Solution Aerosol Protocol. The entire screening and testing procedure shall be explained to the test subject prior to the conduct of the screening test.

(a) Taste threshold screening. The saccharin taste threshold screening, performed without wearing a respirator, is intended to determine whether the individual being tested can detect the taste of saccharin.

(1) During threshold screening as well as during fit testing, subjects shall wear an enclosure about the head and shoulders that is approximately 12 inches in diameter by 14 inches tall with at least the front portion clear and that allows free

movements of the head when a respirator is worn. An enclosure substantially similar to the 3M hood assembly, parts (R) FT 14 and (R) FT 15 combined, is adequate.

(2) The test enclosure shall have a 3/4 inch hole in front of the test subject's nose and mouth area to accommodate the nebulizer nozzle.

(3) The test subject shall don the test enclosure. Throughout the threshold screening test, the test subject shall breathe through his/her wide open mouth with tongue extended.

(4) Using a DeVilbiss Model 40 Inhalation Medication Nebulizer the test conductor shall spray the threshold check solution into the enclosure. This nebulizer shall be clearly marked to distinguish it from the fit test solution nebulizer.

(5) The threshold check solution consists of 0.83 grams of sodium saccharin USP in 1 cc of warm water. It can be prepared by putting 1 cc of the fit test solution (see (b)(5) below) in 100 cc of distilled water.

(6) To produce the aerosol, the nebulizer bulb is firmly squeezed so that it collapses completely, then released and allowed to fully expand.

(7) Ten squeezes are repeated rapidly and then the test subject is asked whether the saccharin can be tasted.

(8) If the first response is negative, ten more squeezes are repeated rapidly and the test subject is again asked whether the saccharin is tasted.

(9) If the second response is negative, ten more squeezes are repeated rapidly and the test subject is again asked whether the saccharin is tasted.

(10) The test conductor will take note of the number of squeezes required to solicit a taste response.

(11) If the saccharin is not tasted after 30 squeezes (step 10), the test subject may not perform the saccharin fit test.

(12) If a taste response is elicited, the test subject shall be asked to take note of the taste for reference in the fit test.

(13) Correct use of the nebulizer means that approximately 1 cc of liquid is used at a time in the nebulizer body.

(14) The nebulizer shall be thoroughly rinsed in water, shaken dry, and refilled at least each morning and afternoon or at least every four hours.

(b) Saccharin solution aerosol fit test procedure

(1) The test subject may not eat, drink (except plain water), or chew gum for 15 minutes before the test.

(2) The fit test uses the same enclosure described in I.B.3.(a) of this appendix.

(3) The test subject shall don the enclosure while wearing the respirator selected in section I.B.3.(a) of this appendix. The respirator shall be properly adjusted and equipped with a particulate filter(s).

(4) A second DeVilbiss Model 40 Inhalation Medication Nebulizer is used to spray the fit test solution into the enclosure. This nebulizer shall be clearly marked to distinguish it from the screening test solution nebulizer.

(5) The fit test solution is prepared by adding 83 grams of sodium saccharin to 100 cc of warm water.

(6) As before, the test subject shall breathe through the wide open mouth with tongue extended.

(7) The nebulizer is inserted into the hole in the front of the enclosure and the fit test solution is sprayed into the enclosure using the same number of squeezes required to elicit a taste response in the screening test.

(8) After generating the aerosol the test subject shall be instructed to perform the exercises in section I.A.14 above.

(9) Every 30 seconds the aerosol concentration shall be replenished using one half the number of squeezes as initially.

(10) The test subject shall indicate to the test conductor if at any time during the fit test the taste of saccharin is detected.

(11) If the taste of saccharin is detected, the fit is deemed unsatisfactory and a different respirator shall be tried.

(12) Successful completion of the test protocol shall allow the use of the tested respirator in contaminated atmospheres

up to 10 times the PEL. In other words, this protocol may be used for assigned protection factors no higher than 10.

4. Irritant Fume Protocol.

(a) The respirator to be tested shall be equipped with high-efficiency particulate air (HEPA) filters.

(b) The test subject shall be allowed to smell a weak concentration of the irritant smoke before the respirator is donned to become familiar with its characteristic odor.

(c) Break both ends of a ventilation smoke tube containing stannic oxychloride, such as the MSA part No. 5645, or equivalent. Attach one end of the smoke tube to a low flow air pump set to deliver 200 milliliters per minute.

(d) Advise the test subject that the smoke can be irritating to the eyes and instruct the subject to keep his/her eyes closed while the test is performed.

(e) The test conductor shall direct the stream of irritant smoke from the smoke tube towards the face seal area of the test subject. He/She shall begin at least 12 inches from the facepiece and gradually move to within one inch, moving around the whole perimeter of the mask.

(f) The exercises identified in section I. A. 14 above shall be performed by the test subject while the respirator seal is being challenged by the smoke.

(g) Each test subject passing the smoke test without evidence of a response shall be given a sensitivity check of the smoke from the same tube once the respirator has been removed to determine whether he/she reacts to the smoke. Failure to evoke a response shall void the fit test.

(h) The fit test shall be performed in a location with exhaust ventilation sufficient to prevent general contamination of the testing area by the test agent.

C. Quantitative Fit Test (QNFT) Protocol.

1. General.

(a) The employer shall assign specific individuals who shall assume full responsibility for implementing the respirator quantitative fit test program.

(b) The employer shall ensure that persons administering QNFT are able to calibrate equipment and perform tests properly,

recognize invalid tests, calculate fit factors properly and assure that test equipment is in proper working order.

(c) The employer shall assure that QNFT equipment is kept clean and well maintained so as to operate at the parameters for which it was designed.

2. Definitions.

(a) **Quantitative fit test.** The test is performed in a test chamber. The normal air-purifying element of the respirator is replaced by a high-efficiency particulate air (HEPA) filter in the case of particulate QNFT aerosols or a sorbent offering contaminant penetration protection equivalent to high-efficiency filters where the QNFT test agent is a gas or vapor.

(b) **Challenge agent** means the aerosol, gas or vapor introduced into a test chamber so that its concentration inside and outside the respirator may be measured.

(c) **Test subject** means the person wearing the respirator for quantitative fit testing.

(d) **Normal standing position** means standing erect and straight with arms down along the sides and looking straight ahead.

(e) **Maximum peak penetration method** means the method of determining test agent penetration in the respirator as determined by strip chart recordings of the test. The highest peak penetration for a given exercise is taken to be representative of average penetration into the respirator for that exercise.

(f) **Average peak penetration method** means the method of determining test agent penetration into the respirator utilizing a strip chart recorder, integrator, or computer. The agent penetration is determined by an average of the peak heights on the graph or by computer integration, for each exercise except the grimace exercise. Integrators or computers which calculate the actual test agent penetration into the respirator for each exercise will also be considered to meet the requirements of the average peak penetration method.

(g) **"Fit Factor"** means the ration of challenge agent concentration outside with respect to the inside of a respirator inlet covering (facepiece or enclosure).

3. Apparatus.

(a) **Instrumentation.** Aerosol generation, dilution, and measurement systems using corn oil or sodium chloride as test aerosols shall be used for quantitative fit testing.

(b) **Test chamber.** The test chamber shall be large enough to permit all test subjects to perform freely all required exercises without disturbing the challenge agent concentration or the measurement apparatus. The test chamber shall be equipped and constructed so that the challenge agent is effectively isolated from the ambient air, yet uniform in concentration throughout the chamber.

(c) When testing air-purifying respirators, the normal filter or cartridge element shall be replaced with a high-efficiency particulate filter supplied by the same manufacturer.

(d) The sampling instrument shall be selected so that a strip chart record may be made of the test showing the rise and fall of the challenge agent concentration with each inspiration and expiration at fit factors of at least 2,000. Integrators or computers which integrate the amount of test agent penetration leakage into the respirator for each exercise may be used provided a record of the readings is made.

(e) The combination of substitute air-purifying elements, challenge agent and challenge agent concentration in the test chamber shall be such that the test subject is not exposed in excess of an established exposure limit for the challenge agent at any time during the testing process.

(f) The sampling port on the test specimen respirator shall be placed and constructed so that no leakage occurs around the port (e.g., where the respirator is probed), a free air flow is allowed into the sampling line at all times and so that there is no interference with the fit or performance of the respirator.

(g) The test chamber and test set up shall permit the person administering the test to observe the test subject inside the chamber during the test.

(h) The equipment generating the challenge atmosphere shall maintain the concentration of challenge agent inside the test chamber constant to within a 10 percent variation for the duration of the test.

(i) The time lag (interval between an event and the recording of the event on the strip chart or computer or integrator) shall be kept to a minimum. There shall be a clear association between the occurrence of an event inside the test chamber and its being recorded.

(j) The sampling line tubing for the test chamber atmosphere and for the respirator sampling port shall be of equal diameter and of the same material. The length of the two lines shall be equal.

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(k) The exhaust flow from the test chamber shall pass through a high-efficiency filter before release.

(l) When sodium chloride aerosol is used, the relative humidity inside the test chamber shall not exceed 50 percent.

(m) The limitations of instrument detection shall be taken into account when determining the fit factor.

(n) Test respirators shall be maintained in proper working order and inspected for deficiencies such as cracks, missing valves and gaskets, etc.

4. Procedural Requirements.

(a) When performing the initial positive or negative pressure test the sampling line shall be crimped closed in order to avoid air pressure leakage during either of these tests.

(b) An abbreviated screening isoamyl acetate test or irritant fume test may be utilized in order to quickly identify poor fitting respirators which passed the positive and/or negative pressure test and thus reduce the amount of QNFT time. When performing a screening isoamyl acetate test, combination high-efficiency organic vapor cartridges/canisters shall be used.

(c) A reasonably stable challenge agent concentration shall be measured in the test chamber prior to testing. For canopy or shower curtain type of test units the determination of the challenge agent stability may be established after the test subject has entered the test environment.

(d) Immediately after the subject enters the test chamber, the challenge agent concentration inside the respirator shall be measured to ensure that the peak penetration does not exceed 5 percent for a half mask or 1 percent for a full facepiece respirator.

(e) A stable challenge concentration shall be obtained prior to the actual start of testing.

(f) Respirator restraining straps shall not be overtightened for testing. The straps shall be adjusted by the wearer without assistance from other persons to give a reasonable comfortable fit typical of normal use.

(g) The test shall be terminated whenever any single peak penetration exceeds 5 percent for half masks and 1 percent for full facepiece respirators. The test subject shall

be refitted and retested. If two of the three required tests are terminated, the fit shall be deemed inadequate.

(h) In order to successfully complete a QNFT, three successful fit tests are required. The results of each of the three independent fit tests must exceed the minimum fit factor needed for the class of respirator (e.g., half mask respirator, full facepiece respirator).

(i) Calculation of fit factors.

(1) The fit factor shall be determined for the quantitative fit test by taking the ratio of the average chamber concentration to the concentration inside the respirator.

(2) The average test chamber concentration is the arithmetic average of the test chamber concentration at the beginning and of the end of the test.

(3) The concentration of the challenge agent inside the respirator shall be determined by one of the following methods:

(i) Average peak concentration

(ii) Maximum peak concentration

(iii) Integration by calculation of the area under the individual peak for each exercise. This includes computerized integration.

(j) **Interpretation of test results.** The fit factor established by the quantitative fit testing shall be the lowest of the three fit factor values calculated from the three required fit tests.

(k) The test subject shall not be permitted to wear a half mask, or full facepiece respirator unless a minimum fit factor equivalent to at least 10 times the hazardous exposure level is obtained.

(l) Filters used for quantitative fit testing shall be replaced at least weekly, or whenever increased breathing resistance is encountered, or when the test agent has altered the integrity of the filter media. Organic vapor cartridges/canisters shall be replaced daily (when used) or sooner if there is any indication of breakthrough by a test agent.

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