

Best Practices for Non-Health Care Employers with On-site Health Care Services





Occupational Safety and Health Act of 1970

“To assure safe and healthful working conditions for working men and women; by authorizing enforcement of the standards developed under the Act; by assisting and encouraging the States in their efforts to assure safe and healthful working conditions; by providing for research, information, education, and training in the field of occupational safety and health.”

This guidance is not a standard or regulation, and it creates no new legal obligations. It contains recommendations as well as descriptions of mandatory safety and health standards. The recommendations are advisory in nature, informational in content, and are intended to assist employers in providing a safe and healthful workplace. The Occupational Safety and Health Act requires employers to comply with safety and health standards and regulations promulgated by OSHA or by a state with an OSHA-approved state plan. In addition, the Act’s General Duty Clause, Section 5(a) (1), requires employers to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm.

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List of Abbreviations and Acronyms

- ABPM** – American Board of Preventive Medicine
- ADA** – Americans with Disabilities Act
- APRN** – Advanced Practice Registered Nurse
- ADN** – Associate Degree of Nursing
- AT** – Athletic Trainer
- BSN** – Bachelor of Science in Nursing
- COHN** – Certified Occupational Health Nurse
- COHN-S** – Certified Occupational Health Nurse Specialist
- CPR** – Cardiopulmonary resuscitation
- DC** – Doctor of Chiropractic
- DPT** – Doctor of Physical Therapy
- ED** – Emergency Department
- EMS** – Emergency Medical Services
- EMT** – Emergency Medical Technician
- GINA** – Genetic Information Nondiscrimination Act
- HCP** – Health Care Professional
- HIPAA** – Health Insurance Portability and Accountability Act
- HR** – Human Resources
- LPN** – Licensed Practical Nurse
- LVN** – Licensed Vocational Nurse
- NHTSA** – National Highway Traffic Safety Administration
- NIOSH** – National Institute for Occupational Safety and Health
- NP** – Nurse Practitioner
- OHN** – Occupational Health Nurse
- OEM** – Occupational and Environmental Medicine
- OSHA** – Occupational Safety and Health Administration
- OWC** – Onsite workplace clinic
- PT** – Physical Therapist
- PA** – Physician Associates/Physician Assistants
- PI** – Performance improvement
- PHI** – Protected health information
- QA** – Quality assurance
- QI** – Quality improvement
- RN** – Registered Nurse

Introduction

“Medical management” in the workplace consists of identifying work-related injuries and illnesses; ensuring appropriate delivery of first aid and medical care; and tracking events. All of these tools help prevent injuries and illnesses from occurring or worsening. Effective medical management helps ensure a healthy workforce; prevents illnesses, injuries, and short- and long-term disability; supports improved surveillance and risk factor identification, and reduces employers’ liability and costs (e.g., medical and workers’ compensation insurance costs). Medical management is an important part of an employer’s overall safety and health management program.

The purpose of this document is to update a prior Occupational Safety and Health Administration (OSHA) publication, *The Occupational Health Professional’s Services and Qualifications: Questions and Answers* (OSHA 3160), which was issued in 1999. Since its publication, OSHA has identified many instances of inappropriate medical management in the workplace. Deficiencies were present at small and large employers in many different industries. This document explains some of the issues and challenges and provides up-to-date information that can help employers create and operate an appropriate medical management program for their workplace.

Chapter 1 addresses first aid and describes its role in medical management. The chapter explains how OSHA’s definition of first aid in OSHA’s Recordkeeping rule (29 CFR 1904¹) differs from common usage in health care delivery. Chapter 2 discusses considerations when developing a medical management program and describes three operational models used by employers. Chapter 3 defines “scope of practice”, the skills and clinical services different health care professionals (HCPs) are allowed to perform. Chapter 4 illustrates how medical management fits into an employer’s overall safety and health management program. Chapter 5 provides some case examples of medical management challenges and solutions. The appendices provide additional information on the types

1. OSHA 29 CFR 1904 <https://www.osha.gov/laws-regs/regulations/standardnumber/1904>

of health care professionals that provide occupational health services, as well as other factors that employers should consider when creating an onsite workplace clinic, and ethical concerns raised by onsite workplace clinics.

Intended Audience

This document is intended primarily for non-health care employers who employ or contract with licensed health care professionals to provide clinical services. In addition to treating injured or ill workers, services may include medical surveillance, health promotion, injury care, and “total worker health programs,” such as the care of conditions with both work- and non-work-related elements. Such employers could have a large workforce distributed across multiple locations. Clinical services often occur at onsite clinics in the workplace. Sometimes the services occur remotely, such as via telephone or video conferencing, including both triage and treatment.

Information in this document will also be useful for health care providers who work, or plan to work, at an employer-run onsite workplace clinic, as well as those who serve in a contractual or consulting capacity to oversee or supervise health care professionals (HCPs) at onsite workplace clinics.

This document was not written for smaller employers that have no plans to offer professional clinical services to workers on-site. However, these employers may benefit from some of the information. In particular, Chapter 1 discusses first aid issues that are relevant to all employers.



Disclaimer

This best practices document is not a standard or regulation. It neither creates new legal obligations nor does it change any existing OSHA standard or regulation. The document is advisory in nature, informational in content, and assists employers in providing a safe and healthful workplace.

The U.S. health care system is complex, as are the corresponding legal issues. Many types of health care professionals provide clinical services. Their roles and qualifications may overlap. Many practitioners providing occupational health services have little formal pertinent training and may be unaware of the other specific Federal laws affecting occupational health practice, including the Health Insurance Portability and Accountability Act (HIPAA), the Genetic Information Nondiscrimination Act (GINA), and the specific OSHA standards, including those on beryllium, lead, and silica, that define clear guidelines on medical surveillance examinations and information sharing between clinicians and employers. Scopes of practice, supervisory requirements, and other clinical performance issues, including recordkeeping and clinical documentation requirements, often differ between states. State laws regulate these aspects of health care.

Therefore, employers should consult with an attorney who specializes in health law if they operate, or plan to operate, an onsite workplace health clinic.

Chapter 1. First Aid and Medical Management

The term “first aid” has a specific meaning in common clinical usage and in OSHA’s first aid standards. This definition should not be confused with specific first aid activities that are referenced in OSHA’s Recordkeeping Standard.

Definitions of “first aid”

A common definition of first aid is “helping behaviors and initial care provided to a person for an acute illness or injury.”² Under this definition provided by the American Heart Association and the American Red Cross, first aid intervenors should know how to access the EMS system and recognize that the scope of first aid is influenced by training and regulatory constraints and requirements³. Similarly, OSHA has stated that first aid “often consists of a one-time, short-term treatment and requires little technology or training to administer.” (Medical and First Aid - What is First Aid? | Occupational Safety and Health Administration ([osha.gov](https://www.osha.gov)))³ Common usage of the term “first aid” therefore suggests that it involves initial care, is time-limited in nature, and has as a primary function providing access for needed follow-up, including emergency transport and advanced care.³

OSHA has clarified through a [letter of interpretation](#)⁴ and a [guidance document](#)⁵ that first aid is care that occurs before definitive medical treatment is available. In addressing OSHA’s general industry and construction standards on first aid, OSHA has stated that “the basic purpose of these standards is to assure that adequate first aid is available in the critical minutes between the occurrence of an injury and the availability of physician or hospital care for the injured employee.”⁴ OSHA states clearly that “First aid is emergency care provided for injury or sudden illness before emergency medical treatment is available.”⁴

2. AHA ARC first aid <https://cpr.heart.org/en/resuscitation-science/first-aid-guidelines/first-aid#:~:text=We%20define%20first%20aid%20as%20helping%20behaviors%20and,by%20anyone%20in%20any%20situation%20and%20includes%20self-care>

3. Letter of Interpretation to Charles Brogan, January 16, 2007 <https://www.osha.gov/laws-regs/standardinterpretations/2007-01-16-0>

4. Best Practices Guide: Fundamentals of a Workplace First-Aid Program <https://www.osha.gov/sites/default/files/publications/OSHA3317first-aid.pdf>

What OSHA standards discuss first aid?

The OSHA Medical Services and First Aid standard for General Industry (29 CFR 1910.151) requires that a person “be adequately trained to render first aid” at all workplaces where there is no “infirmary, clinic, or hospital in near proximity to the workplace which is used for the treatment of injured employees.”

OSHA interprets “near proximity” as within 3-4 minutes of the workplace and interprets “infirmary, clinic, or hospital,” as including trained emergency service providers like fire department paramedics or EMS responders. (www.osha.gov/laws-regs/standardinterpretations/2007-01-16-0). The standard also requires that employers ensure that medical personnel are readily available for advice and consultation. The specific details of an employer’s first aid and medical services program may be tailored to the circumstances of the workplace and employer.⁵

Specific OSHA standards also require medical and first aid services for shipyard employment, marine terminals, longshoring, logging, electric power generation, commercial diving, and construction. Employers should review applicable [standards](#).

Most of these specific OSHA standards suggest minimum requirements for first aid kits in mandatory or non-mandatory appendices. Several OSHA standards also require CPR training: [1910.146 Permit-required Confined Spaces](#); [1910.266 Appendix B: Logging Operations – First-Aid and CPR Training](#); [1910.269 Electric Power Generation, Transmission, and Distribution](#); [1910.410 Qualifications of Dive Team](#); [1926.951, 1926.968 Construction Subpart V, Power Transmission and Distribution](#).

OSHA’s list of “first aid” actions for recordkeeping purposes

OSHA’s Recordkeeping rule (29 CFR 1904) requires that employers record certain work-related injuries and illnesses on OSHA’s Form 300 Log of Work-Related Injuries and Illnesses. In section 1904.7(b)(5)(ii) of the standard, OSHA lists 14 therapies that constitute “first aid” for the purposes of OSHA recordkeeping. These OSHA-designated first aid actions are:

5. Letter of Interpretation to David Nakama, November 1, 2005 <https://www.osha.gov/laws-regs/standardinterpretations/2005-11-01>.

1. Using a non-prescription medication at nonprescription strength,
2. Administering tetanus immunizations,
3. Cleaning, flushing or soaking wounds on the surface of the skin,
4. Using wound coverings such as bandages, Band-Aids™, gauze pads, etc.; or using butterfly bandages or Steri-Strips™,
5. Using hot or cold therapy,
6. Using any non-rigid means of support, such as elastic bandages, wraps, or non-rigid back belts,
7. Using temporary immobilization devices while transporting an accident victim (e.g., splints, slings, neck collars, back boards, etc.),
8. Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister,
9. Using eye patches,
10. Removing foreign bodies from the eye using only irrigation or a cotton swab,
11. Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means,
12. Using finger guards
13. Using massages, or
14. Drinking fluids for relief of heat stress.

If an injury or illness receives one of these 14 first aid actions only, and does not meet any other recordkeeping criteria in the standard, then the employer is not required to record the incident on OSHA's Form 300. If the injury or illness meets one of the six criteria for recordability, such as restriction on work activity or inability to work, including inability to perform work that occurs at least once per week (1904.7(b)(4)(ii)), meeting the criteria for the "first aid exclusion" does not release an employer from the obligation to record the case on the log. While OSHA considers these actions to be examples of first aid, they do not provide a comprehensive definition of what is or is not included in the clinical definition of first aid.

OSHA's Recordkeeping rule does not imply that the listed first aid actions are safe and appropriate in all or repeated situations. Nor does the Recordkeeping rule's list of first aid actions imply that it is appropriate to provide "first aid" several times, during multiple encounters, for the same injury. In some cases, the need to repeatedly apply first aid may alert the first aid provider to the possibility that an underlying condition may need further medical treatment beyond first aid. A qualified person must make such clinical decisions about appropriate medical treatment on a case-by-case basis. Employers can consult an attorney or use the table at the end of this document, which contains a list of health care professionals, and their license and scope of practice characteristics.

What first aid issues should employers consider when developing a medical management program?

First aid is part of a comprehensive medical management strategy. OSHA's [Best Practices Guide](#) (2006) describes the fundamental components of a workplace first aid program. These include assessing risks, designing a first aid program, assigning and training first-aid responders, and periodically evaluating the program's effectiveness. Because of the complexity of the topics involved, employers should consider consulting with a physician or certified occupational health nurse (COHN) to help design and evaluate their program including through formal independent audits.

The first aid provider in the workplace has typically received training in the delivery of initial emergency medical procedures, using a limited amount of equipment to perform a primary assessment and intervention, and to recognize common major adverse events like strokes and sudden death. Some employers hire licensed health care professionals, such as RNs, physical therapists, or emergency medical technicians (EMTs), to be onsite to perform first aid. Many other employers provide basic first aid training to employees and/or supervisors who otherwise have no specialized clinical qualifications. Employers relying on first aid-trained employees should ensure those employees

are scheduled and available on all shifts to provide first aid services to injured or ill workers and should recognize that these employees require bloodborne pathogens training⁶.

When designing a first aid program, employers should keep in mind the common, clinically relevant definition of first aid. First aid is the *initial* care of an event or injury.³ It precedes definitive assessment of the need for medical care by someone who accepts that responsibility. Under the common, clinical meaning, first aid does not involve multiple encounters with the same patient presenting the same concerns, unless there has been resolution and a new event has occurred.

Workplace first aid encompasses all actions and decisions involved in the *initial* care of injured or ill workers onsite, until the worker(s) are referred or transported for higher-level medical care. In some cases, an injury or illness is so minor that it resolves with first aid, and referral or transport is unnecessary. However, an employer's first aid providers often lack the qualifications and professional licensing to make medical diagnoses or triage decisions. First aid providers should have clear instructions to consult with medical personnel as necessary, such as by a referral through the 911-EMS system or phoning a physician helpline. An employer's first aid providers should not create barriers or prevent a worker from seeing a health care provider for definitive diagnosis and treatment. Even if the condition is clearly within their scope of practice and they have a formal relationship with the employee/patient under the workers compensation system, they may need to consult their local regulations. For further information about these issues, see the discussion of "scope of practice" in Chapter 3.

Additional General Resources

- OSHA's [Medical and First Aid Topics](#) page.
- OSHA [Standards with first aid](#) requirements.
- OSHA's [Recordkeeping and Reporting Requirements](#) Topics page.
- [OSHA Best Practices Guide: Fundamentals of a Workplace First-Aid Program](#)

6. Letter of Interpretation to Charles Brogan, January 16, 2007: <https://www.osha.gov/laws-regs/standardinterpretations/2007-01-16-0>

Chapter 2. Developing a Medical Management Program

Medical management programs are not one-size-fits-all. Employers should tailor them to each workplace. For instance, a construction company that moves from site to site may need very different programs than an integrated steel plant. A chemical manufacturing company that uses hydrofluoric acid will need special first aid training, procedures, and supplies to prevent serious chemical burns in the event of an accidental exposure. In fact, large employers may even need to develop a different program for each facility. **OSHA strongly recommends that employers consult occupational health professionals when developing a program.**

Below is a list of factors an employer should consider when developing a medical management program. This list does not focus on broader, non-clinical aspects of employer medical programs, such as total worker health, health and productivity, and wellness programs, although there are substantial overlaps.

- Physical, chemical, biomechanical, and biological hazards present in the workplace.
- Work organization characteristics that can present a hazard to workers, such as shift work, long hours, or fast-paced work.
- Demographics of the workforce, such as age, sex, languages spoken, and turnover rates.
- Workplace location and size, mobile worksites, and distance to health care facilities.
- State and Federal laws governing the practice of health care.
- State and/or Federal laws that may be applicable to certain jobs or exposures, such as the Federal Motor Carrier Safety Administration (FMCSA) medical requirements for commercial motor vehicle drivers engaged in interstate commerce.
- OSHA's standards that require [first aid](#) and [medical surveillance](#) (see *Additional Resources* below).
- Occupational health expertise both within and outside the company.
- The role of medical management in the employer's overall workplace safety and health management program.

In OSHA's experience, companies that offer onsite medical management services, with licensed health care providers, typically implement one of three organizational models described below.

Model #1: Corporate Medical Director. Some businesses employ an on-staff medical director. The medical director is often a physician but may be an advanced practice registered nurse (APRN). The medical director oversees a corporate medical department whose staff may include occupational health nurses (OHN) and/or other health care professionals. Under the guidance and supervision of the medical director, these staff deliver medical services at one or more corporate locations.

Model #2: Contract Medical Organization. An employer may contract with a health care organization to provide medical services onsite or offsite. The employer has no medical director on its direct payroll. Instead, the contracted organization manages all medical services. A medical director at the contracted organization is often responsible for overseeing services across multiple client sites.

Model #3: Program Lacking Director. A third model differs substantially. An employer hires health care providers, such as EMTs or LPNs, who are required by state licensing and scope of practice regulations to work under the direction of an independently licensed practitioner such as a physician or APRN. *However, the employer does not hire a medical director.* As a result, no staff physician or APRN performs clinical supervision of the providers who provide the onsite health care services. Employers should consult state laws and regulations to determine whether this organizational model is consistent with local requirements regarding supervision or scope of practice.

Some of these employers consult initially with an outside physician who writes clinical protocols to guide the onsite health care staff. However, after the initial phase of protocol development ends, the consulting physician often provides little or no oversight for the employer's onsite clinic.

OSHA has encountered medical management problems when organizations fail to provide medical direction and oversight⁷. These problems are discussed in more detail in subsequent chapters and in the case studies in Chapter 5. In some cases, OSHA has made referrals to state licensing bodies when it has observed HCPs who appear to be functioning beyond their approved scope of practice. In addition, OSHA has cited employers under various standards, such as the medical services and first aid standard⁸, as well as section 5(a)(1) of the OSH Act, 29 U.S.C. § 654(a)(1). OSHA can also cite under aspects of other standards such as silica⁹, beryllium¹⁰, and methylene chloride¹¹ when employers fail to follow specific elements of the standard.

Additional Resources:

- OSHA’s [Medical Screening and Surveillance Topics](#) page has additional resources and lists the [OSHA Standards requiring medical surveillance](#).
- [OSHA First Aid requirements](#)

7. Tustin AW, Fagan KM, Hodgson MJ. “What are a consulting physician’s responsibilities when reviewing and approving the medical protocols of a company’s on-site clinic?” *Journal of Occupational and Environmental Medicine*. 2018;60(7):e321-e323

8. 1910.151 - Medical services and first aid. | Occupational Safety and Health Administration ([osha.gov](#))

9. 1910.1053 - Respirable crystalline silica. | Occupational Safety and Health Administration ([osha.gov](#)) AND [osha standard 29 cfr 1926.1153](#) - Search ([bing.com](#))

10. 1910.1024 - Beryllium. | Occupational Safety and Health Administration ([osha.gov](#))

11. 1910.1052 - Methylene chloride. | Occupational Safety and Health Administration ([osha.gov](#))

Chapter 3. Occupational Health Care Professionals and Scope of Practice

Various health care professionals (HCPs) provide occupational health services at worksites. These HCPs include physicians, advanced practice registered nurses (APRN), nurse practitioners, clinical nurse specialists, physician assistants (PA), registered nurses (RN), licensed practical nurses (LPN), licensed vocational nurses (LVN), emergency medical technicians (EMT), athletic trainers, physical therapists (PT), and others. In the Contract Medical Organization model, described in Chapter 2, an employer contracts with an outside organization that provides clinical staffing. However, if the employer hires onsite HCPs directly, the employer should understand those HCPs' scopes of practice and requirements for licensure, registration, or certification.

What does scope of practice mean?

State governments license HCPs. In general, it is unlawful for HCPs to provide health care services without a license to practice in the state where they work. "Scope of practice" refers to the skills and clinical services an HCP is licensed to perform under state law. For example, prescribing medications is within the scope of practice for a physician, but not for an EMT. The legal scope of practice can vary by state for a given type of HCP. Scope of practice laws usually indicate whether an HCP can work independently. State laws may also specify supervisory requirements, as well as clinical documentation, recordkeeping and quality management requirements, although these requirements vary greatly. Thus, employers who hire HCPs should review their state's regulations on scopes of practice and confirm that the HCPs are properly licensed and have adequate clinical supervision. States often require renewal of licenses on a regular basis, typically every few years. Continuing education is often required for both state licenses and professional re-certification. Corporate medical directors, who do not provide direct clinical services, may not require licensing in each State, although oversight

of clinical staff usually requires a license in the State where practice occurs. Some states have meanwhile distinguished between administrative and clinical licenses.

Why is scope of practice important?

Employers who are not in the health care industry may not understand the laws governing HCP scope of practice. In some situations, where there is no director providing supervision, employers may create a system where HCPs exceed their scope of practice. The result can be harmful to workers and endanger the HCP's licensure status. Take the following example:

A warehouse employer sets up an onsite workplace clinic called "the nursing station." The employer plans to provide first aid and follow-up care to workers, many of whom experience frequent shoulder and back pain. The employer hires an LPN to assess these workers and give them therapies, such as cold packs, that meet the OSHA definition of "first aid." The employer assumes that if there is a serious injury, the LPN will be able to refer the worker for appropriate medical care. What the employer does not realize is that per state law, the newly hired LPN cannot work without direct supervision by an RN, APRN, or physician. While the LPN may call an ambulance in an emergency situation, the LPN's scope of practice does not include decision-making about referring a patient for other higher-level medical care.

In this example, by providing nursing services without proper supervision, the LPN may have exceeded their legal scope of practice. By exceeding their scope of practice, the LPN is at risk of losing their license. The warehouse workers are at risk of more serious injuries if the LPN provides inappropriate treatment (e.g., if cold packs are not the correct therapy for their conditions) or fails to make timely referrals for definitive evaluation and treatment. The employer may be at risk of higher workers' compensation claims, disability costs, and productivity losses.

In a traditional health care setting, such as a hospital or clinic, the organizational structure and staffing ensure that patients receive evaluation and treatment from HCPs whose scopes of practice are appropriate to the level of care being provided. These safeguards may not be present at employer-run clinics, particularly where there is no director providing supervision.

How can employers know that they are hiring the appropriate health care professionals for their onsite health care services?

Employers should consult a health law attorney prior to offering onsite medical services or hiring HCPs. In addition, OSHA recommends that employers consult with and/or hire HCPs who specialize in occupational health. Two types of HCPs—physicians and nurses—can possess specialty training in occupational health; physicians and some nurses may sit for board certification.

Professional Certifications

Certified Occupational Health Nurses (COHN) and Certified Occupational Health Nurse Specialists (COHN-S)

The terms COHN and COHN-S refer to APRNs and RNs who have completed academic training in occupational health and who have passed the respective certifying exam from the Association of Occupational Health Nurses (AOHN). COHN/COHN-S comprise the preferred category of qualified nurses for onsite health care services. In addition to providing direct care to injured workers, COHN/COHN-S can manage workers' compensation programs, provide health and safety training, implement medical surveillance programs, and manage other occupational health programs and services. In general, the COHN-S certification has greater management and administration skills than the COHN.

Occupational and Environmental Medicine (OEM) Physicians

Physician specialization in occupational medicine (also known as occupational health) requires a one-year clinical internship and a two-year occupational medicine residency after medical school. This residency training includes a Master of Public Health or equivalent degree. The physician must then pass a certifying examination to become “board certified” in occupational medicine. OEM Physicians often practice clinical occupational medicine, such as treating injured workers. Other OEM Physicians oversee clinical occupational health programs, pursue a career in policy or public health, or work as corporate medical directors. OEM Physicians frequently advise employers on a multitude of workplace health and safety issues, including onsite health care services.

The Appendix contains more information about physicians and nurses, including how to find or verify certification of an OEM Physician or COHN/COHN-S. The Appendix also provides details about other HCPs that provide occupational health services. General information in the Appendix includes HCP education, certification, licensing, supervision, and scopes of practices. However, employers should check with a health law attorney or their state authorities for the most current regulations.

Chapter 4. Medical Management’s Role in Workplace Safety and Health Programs

In 2016, OSHA updated its guidance to employers on best practices to prevent workplace injuries, illnesses and deaths. The Recommended Practices for Safety and Health Programs (available as a [webpage](#) or as a [PDF booklet](#)) uses a proactive approach to find and fix hazards before they cause injury or illness. Core elements of a workplace safety and health program include:

- Management leadership
- Worker participation
- Hazard identification and assessment
- Hazard prevention and control
- Education and training
- Program evaluation and improvement
- Communication and coordination for host employers, contractors, and staffing agencies

A strong medical management program can support several of these elements. [Hazard identification and assessment](#) involves, among other things, collecting and reviewing information on workplace injuries, illnesses, incidents, and near misses. Useful medical data include the OSHA Form 300 Log of Work-Related Injuries and Illnesses, workers’ compensation claims, OWC logs and records, first aid logs, worker complaints, and incident reports. These data create a surveillance infrastructure. Employers can detect and control hazards by grouping similar incidents, investigating and analyzing injury trends, studying emergency events, and tracking unsafe conditions and near misses. After changes are made, the same data sources can be used to [evaluate the safety and health program](#) and verify that interventions are working. Occupational health professionals, such as COHN/COHN-S and OEM Physicians, can aid employers in analyzing the medical data and recommending workplace controls.

A key component of a successful safety and health program is [worker participation](#). In addition to reporting hazards, workers should be encouraged to report symptoms and injuries. For this reason, OSHA regulations require employers to establish a reasonable procedure for reporting work-related injuries and illnesses. Section 11(c) of the OSH Act, as well as OSHA Recordkeeping regulations (29 CFR 1904.35), prohibit discrimination against any employee for reporting a work-related injury or illness.

A proactive safety and health program will prevent future injuries, goes beyond compliance with laws and regulations, reduces future workers' compensation costs, and increases productivity and overall business operations. A safe and healthy workplace is sound business!

Additional Resources:

- [Recommended Practices for Safety and Health Programs. \[PDF booklet\]](#) OSHA, October 2016.
- [Recommended Practices for Safety and Health Programs. \[webpage\]](#) OSHA, October 2016.

Chapter 5. Case Studies

Case 1 – First Aid or Medical Care?

A large steel plant hired EMTs to respond to emergencies and severe injuries. Over time, the employer expanded the EMTs' role to include first aid and follow-up care for other minor injuries. The EMTs continued to refer severe injuries (e.g., lacerations, fractures, head trauma) to the local hospital Emergency Department (ED) via 911. However, when they diagnosed a worker with a sprain or strain, the EMTs frequently provided "first aid" like ice packs and nonprescription pain medicine across multiple clinic visits spanning days to weeks. Sometimes workers got better and stopped seeing the EMTs. Sometimes EMTs referred workers to outside clinics when their symptoms did not resolve. Other workers stopped going to the EMTs because the repeated "first aid" was not helping.

The employer believed that since ice and nonprescription medicines were within OSHA's definition of first aid under the recordkeeping standard, the services provided by the EMTs were simply first aid and not medical care. In addition, the employer was happy that the EMT services decreased workers' compensation costs and OSHA 300 Log cases.

What are the medical management errors in Case 1?

When EMTs (or any other HCPs) evaluate and treat a worker more than once for the same injury, they are providing medical care, not first aid. As discussed in Chapter 2, properly designed health care systems recognize that first aid is *initial* care only. Providing only OSHA recordkeeping-designated "first aid" treatments over multiple clinic visits does not mean that the medical care is actually first aid. Furthermore, these EMTs may be making medical diagnoses, possibly outside their scope of practice, and a potential violation of state licensure rules.

OSHA has seen many examples where employers misunderstood the clinical difference between first aid and medical care. The elements of medical care include a clinical history, physical examination, assessment, and management

plan. For example, imagine that a maintenance worker at the steel plant repairs a machine, which requires forceful overhead use of a wrench. At the end of the shift, he sees the EMT in the clinic for shoulder pain. The EMT asks questions about the symptoms and any previous injuries to the shoulder (clinical history); examines the shoulder for tenderness, swelling and range of motion (physical examination); decides that the worker strained his shoulder (assessment or diagnosis); and tells the worker to use ice on the shoulder, take over-the-counter ibuprofen, and return the next day for re-evaluation (management plan). The ice and ibuprofen are on the OSHA recordkeeping first aid list, but the entirety of this clinical encounter comprises medical care which may be beyond the EMT's allowed scope of practice. Of course, any follow-up visits and treatments would also not meet the clinical definition of "first aid."

What are possible adverse outcomes?

Generally, EMT training and scope of practice do not include follow-up evaluation and treatment of musculoskeletal injuries. Without appropriate supervision and protocols, adverse outcomes may include prolonged, inappropriate treatment, lack of appropriate referral, and increased injury severity. For instance, in the above scenario, if the EMT does not refer the worker to a higher-level HCP, a rotator cuff strain could progress to a tear that needs surgery. At other facilities, OSHA has seen cases where missed diagnoses, such as chemical eye burns and concussions, have led to worse outcomes.

What can the employer do to improve medical management in Case 1?

For guidance in setting up a first aid program or first aid station, the employer can refer to OSHA's 2006 [Best Practices Guide: Fundamentals of a Workplace First-Aid Program](#). The employer should review state laws governing EMTs' scope of practice and supervision to ensure that the EMTs are practicing within the legal requirements. The EMTs' clinical supervisor, usually a physician, should frequently review the

care provided by the EMTs, provide guidance and education, and take corrective action when medical management errors occur. If a worker's symptoms have not improved after the EMT provides first aid, the employer should have a clear procedure for referral to an outside HCP or ED. This procedure should be independent of employer's safety professionals' and HR professionals' opinions. The employer should ensure that workers are encouraged to report injuries and seek necessary treatment.

Case 2 – Why is Clinical Supervision Important?

A poultry processing plant hires LPNs to staff their onsite nursing station. The LPNs evaluate and treat injured workers and decide when to send a worker to the hospital emergency department or to a medical clinic for non-emergency treatment. The LPNs' supervisor is the company safety director, a former EMT.

To guide the LPNs, the safety director gives them a set of medical protocols that he used in his previous job with an ambulance service. Most of the protocols address severe acute conditions such as cardiac arrest and hypoglycemia. The employer asks a local physician, whose clinic occasionally treats injured workers from the plant, to review the protocols and approve their use at the plant.

In the past, the physician has provided medical care to workers from this plant who had back and wrist sprains. Therefore, she updates the protocol document by adding instructions for first aid of these complaints. The protocols do not address when a worker with a back and wrist sprain would need to be referred for medical treatment. The physician then signs the revised protocols. After doing so, she has no further formal relationship with the plant. She does not supervise the LPNs or provide follow-up care to injured workers.

The employer tells workers that they cannot go to their own doctor for a work injury. Instead, they must go to the nursing station and see an LPN, who will refer them to a doctor if needed.

What are the medical management errors in Case 2?

There are two primary medical management errors. First, the LPNs do not have proper clinical supervision. According to the state's Board of Nursing regulations, a physician, APRN, or RN, must supervise LPNs. Second, the LPNs are working beyond their scope of practice by referring workers to a doctor for non-emergency treatment. LPNs generally do not have the training to provide evaluation and treatment of work-related musculoskeletal disorders or to make decisions about further medical care for such disorders. When OSHA staff have concerns regarding appropriate medical treatment of workers, OSHA staff has referred providers to state licensing boards for further review. OSHA recommends consulting the state workers' compensation authority and a health law attorney.

What are possible adverse health outcomes?

The plant's medical protocols allow the LPNs to treat injuries for periods of weeks to months without referral to a higher-level provider for definitive evaluation, diagnosis, and treatment. Delayed treatment can exacerbate injuries and illnesses. Furthermore, LPNs may encounter injuries for which they have no training or experience. Without proper clinical supervision, the LPNs may provide inappropriate treatment.

These risks are not just theoretical. OSHA has seen adverse health outcomes due to poor medical management. For instance, a plant's onsite HCPs treated a wrist sprain for months without referral. A physician later diagnosed carpal tunnel syndrome, which required surgery. Early diagnosis and treatment of carpal tunnel syndrome might have reversed the symptoms and prevented the need for surgery. In another case that OSHA reviewed, an LPN did not recognize frostbite of the finger. As a result, the LPN failed to refer the worker for immediate evaluation and treatment. The worker's finger eventually had to be amputated.

What can the employer do to improve medical management in Case 2?

Employers should review state and federal health care laws and consult a health law attorney. An OEM physician or an APRN should design an employer's onsite health services. The structure of onsite services should include appropriate clinical supervision of the health care staff.

In addition, physicians who sign medical protocols for onsite workplace clinics have a responsibility to understand the circumstances in which the protocols are to be used. The physician should understand the scopes of practice of the staff and the clinical supervisory structure. The following peer-reviewed reference provides guidance to physicians who review and approve employers' medical protocols:

- Tustin AW, Fagan KM, Hodgson MJ. What are a consulting physician's responsibilities when reviewing and approving medical protocols of a company's on-site clinic? *Journal of Occupational and Environmental Medicine*. 2018; 60(7):e321-e323.

Case 3 – Confidentiality and the Multilingual Workforce

A meatpacking plant has an onsite clinic staffed by RNs, LPNs, and a physician who comes onsite once a week. The company hires many immigrant workers. Over 50% of the employees do not speak English. Languages include Spanish, Haitian Creole, and Hmong. The clinic staff only speak English. When non-English-speaking or limited English proficient workers come to the clinic, bilingual co-workers or supervisors perform language interpretation. Sometimes there is no one available to interpret. In those situations, the injured workers attempt to communicate with the HCPs via hand gestures and broken English.

What are the medical management errors in Case 3?

The errors in this case are poor communication and lack of confidentiality in a clinical setting.

If an HCP cannot communicate effectively with a worker, it is almost impossible to provide appropriate care. Inappropriate care may be dangerous. Using co-workers or other company personnel as interpreters is a poor solution to the language barrier, because these “informal” interpreters may be unable to interpret complex medical discussions accurately.

Informal interpreters may also violate patients’ rights because they are unfamiliar with confidentiality requirements.

Confidentiality is a fundamental principle of both the ethical and legal practice of medicine. Bridging language barriers in a confidential manner is particularly important in creating an effective and safe clinical environment. The use of untrained co-workers or other company personnel to interpret is inappropriate, as this practice breaches confidentiality.

What are possible adverse outcomes?

When co-workers or supervisors interpret clinical encounters, workers may be uncomfortable confiding important information needed to make a diagnosis or clinical decision. Workers may minimize symptoms or underreport the length of time the symptoms have been occurring, leading to a delay in diagnosis and treatment. Health care staff who cannot communicate effectively may misunderstand or minimize workers’ symptoms, leading to inappropriate clinical management.

OSHA has seen such cases. For example, a worker developed trigger finger, a condition of inflammation, swelling, and a lump on a hand tendon, after working with vibrating tools and an inadequately padded handle. That injury could have resolved with temporary work restrictions and a cortisone injection. Instead, it resulted in surgery and chronic disability. This happened because the employer’s onsite clinical staff did not speak the worker’s language or have access to a confidential interpretation service. The worker could not communicate her symptoms and aggravating factors, or her questions and concerns. The onsite staff did not provide counseling in the language the worker could understand. Thus, the worker believed that nothing could be done to treat her finger.

What can the employer do to improve medical management in Case 3?

As the number of people with Limited English Proficiency (LEP) has increased in the U.S., health care standards require that confidential interpretation services be available (Chen 2007; JC, 2012; CMS, 2011). Specific training and certification for health care interpreters is in place in the U.S., ensuring that competent and confidential interpretation services are easily available (JC Resources 2012).

Additional resources:

- Karliner LS, Jacobs EA, Chen AH, Mutha S. [Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature.](https://pubmed.ncbi.nlm.nih.gov/17362215/) Health Serv Res. 2007 Apr;42(2):727-54. doi: 10.1111/j.1475-6773.2006.00629.x. <https://pubmed.ncbi.nlm.nih.gov/17362215/>
- Center for Medicare and Medicaid Services. Understanding Communication and Language Needs of Medicare Beneficiaries <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf>
- Joint Commission Resources. Advancing Effective Communication, Cultural Competence, and Family-Centered Care: A Roadmap for Hospitals. <https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/health-equity/roadmapforhospitalsfinalversion727.pdf?db=web&hash=AC3AC4BED1D973>.

Case 4 – What is the Supervisor’s Role When a Worker Gets Injured?

A cleaning company provides contract services to meatpacking plants around the country. Because the cleaning work happens on the night shift, and the plants are in remote locations, finding reliable health services for injured workers can be difficult. In an attempt to solve this problem, the cleaning company contracts with a telephone triage service staffed by RNs.

Whenever a cleaning worker reports an injury or symptoms, the supervisor calls the triage service and speaks to an RN to ask for advice. When injured workers ask to talk to the RN, they can do so. However, in most instances, the supervisor talks directly to the RN, particularly if the injured worker does not speak English.

Some workers distrust this arrangement, in which supervisors communicate directly with the HCPs, because the workers are uncomfortable giving their supervisor personal details that might affect their injury care or employment. Other workers do not understand that they can ask to talk directly to the RN.

What are the medical management errors in Case 4?

As with Case 3, the primary error is lack of confidentiality with the additional problem of possible inaccurate diagnoses. Supervisors clearly have an integral role in an employer’s medical management program. Immediate supervisors are generally the first to hear about a symptom or injury. Part of a supervisor’s job is to track injuries and report them up the line. However, confidentiality is compromised unnecessarily when workers are forced to use supervisors as “go-betweens” to communicate with HCPs who administer first aid or medical care.

Another issue is that HCPs who provide remote services (e.g., via telephone) may not be properly supervised or licensed in the state where the patient is located. Before contracting with any telehealth service, such as a telephone triage provider, employers should consult with an attorney who specializes in health law. The attorney can review the telehealth contractor’s supervision and staffing, to ensure that all legal and clinical requirements are satisfied.

What can the employer do to improve medical management in Case 4?

Training of supervisors is key. Training should include a clear description of the role and responsibilities of the supervisors in the company's overall medical management program. Training should cover confidentiality and methods to encourage workers' reporting of symptoms and injuries. Supervisors should encourage all injured workers to speak directly to the triage RNs.

Worker training is also important. Both workers and supervisors should have the same understanding of the company's medical management program. The program should include methods to encourage early reporting and treatment of injuries. For instance, more workers may utilize the triage service if they are allowed to call without going through the supervisor.

Appendix I – Types of Health Care Professionals

The U.S. health care system involves a variety of health care professionals who work together to provide clinical services. This Appendix describes some common types of HCPs who work in occupational settings. The purpose of this Appendix is to provide basic information about HCPs to employers who are designing a medical management program.

The inclusion of a type of HCP in this Appendix does not imply endorsement by OSHA. Nor does it imply that the type of HCP is qualified to work in any particular occupational setting. As always, employers should consult an attorney with experience in health law.

1 - Physicians

Physicians have traditionally provided most of the care for acute and chronic work-related injuries and illnesses. Physicians also perform other occupational examinations, such as pre-placement exams, medical surveillance exams, and independent medical exams. Both Doctors of Medicine (MDs) and Doctors of Osteopathy (DOs) are physicians. Physicians have completed study at the college level and post-graduate education at an accredited medical school. Licensed physicians have passed the U.S. Medical Licensing Examination or other National Board of Medical Examiners' equivalent examination, have a license to practice medicine within a given state(s), and can practice medicine independently. A physician's scope of practice includes diagnosing and treating injuries and illnesses, prescribing treatments and medications, and supervising other HCPs.

Most physicians choose a specialty (such as Family Medicine or Surgery) and obtain further training and skills. Physicians who complete further training (residencies and fellowships) and pass qualifying examinations (called "boards") become board certified in their specialty. Physicians are licensed through the state's medical board. Employers should regularly verify through the state medical board that the physician has a valid license to practice medicine in the state in which the physician is

working. To verify specialty training and board certification for physicians, employers can access online information through the [American Board of Medical Specialties](#).

1.1 – Occupational and Environmental Medicine Specialists

Occupational and Environmental Medicine (OEM) Physicians are MDs or DOs who have completed additional occupational medicine training. Completion of an accredited occupational medicine residency and further practice in occupational medicine enables physicians to pursue board certification in occupational medicine. Board certified OEM physicians have passed an examination in occupational medicine given by the American Board of Preventive Medicine (ABPM).

OEM physicians are experts in the health of workers. The scope of practice of OEM physicians includes the diagnosis and treatment of work-related injuries and illnesses, epidemiology, knowledge of occupational laws and regulations, clinical toxicology, worker fitness and disability management, and prevention of occupational injury and disease. OEM physicians regularly consult with employers on workplace safety and health management. OEM physicians supervise occupational health services, including onsite services and staff. An [ABPM online database](#) allows the public to verify a physician’s OEM board certification and search for board certified OEM physicians in any U.S. city or state.

1.2 – Physicians in other specialties

Most physicians are not specially trained in occupational medicine. Many physicians who treat injured workers or perform pre-placement and medical surveillance exams are not OEM physicians. Employers who hire physicians should ask the physicians about their training and experience in occupational medicine.

Some OSHA medical surveillance requirements either recommend (e.g., the Asbestos standard) or require (e.g., the Silica standard) that physicians who evaluate chest X-rays be certified as B readers. A [certified B reader](#) has taken the

National Institute for Occupational Safety and Health (NIOSH) course, and passed the certifying test to evaluate chest X-rays under the International Labour Organization (ILO) program for pneumoconioses (dust diseases of the lung).

Additional resources:

- American College of Occupational and Environmental Medicine (ACOEM). Position Paper on [Scope of Occupational and Environmental Health Programs and Practice](#)
- The [Association of Occupational and Environmental Clinics](#) (AOEC) is a network of clinics throughout the United States staffed by OEM physicians and other occupational health professionals. The AOEC clinic directory is here: <https://aoec.org/members>
- The [National Institute for Occupational Safety and Health](#) (NIOSH) has Education and Research Centers (ERCs) throughout the country. The primary purpose of the ERCs is to train occupational safety and health professionals and researchers, including OEM physicians. These NIOSH ERCs can be a resource for employers. Information on the NIOSH ERCs is here: <https://www.cdc.gov/niosh/extramural-programs/php/about/ercs.html>
- NIOSH also supports Centers for Agricultural Safety and Health throughout the country. These centers can be a resource for agricultural employers. Information on these agricultural centers is here: <https://www.cdc.gov/niosh/extramural-programs/php/about/ag-centers.html>
- OSHA's webpage for [Clinicians](#) has guidance for physicians and other HCPs. These resources may also be helpful to employers.

2 – Physician Assistants

Physician Assistants (PAs) provide patient care as part of a health care team, under the supervision of a physician. PAs may perform physical examinations, diagnose and treat illnesses, order and interpret tests, prescribe medications (in most states), and plan and implement therapeutic interventions. State laws require that PAs work under the supervision of a licensed physician.

PAs must graduate from a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). To become certified, PAs must pass a national certification exam administered by the National Commission on Certification of Physician Assistants. PAs must be licensed by the state in which they practice. PAs maintain their certification through annual continuing education. They must pass a recertification examination every 6 to 10 years.

Some PAs practice in occupational health settings. Although there is no special occupational health certification for PAs, interested PAs can join a professional organization such as the [American Academy of Physician Assistants in Occupational Medicine](#), which provides educational opportunities and resources for PAs working in this specialized area.

Additional resources:

- American Academy of Physician Assistants: <https://www.aapa.org>
- Accreditation Review Commission on Education for the Physician Assistant: <http://www.arc-pa.org>
- National Commission on Certification of Physicians Assistants: <https://www.nccpa.net>
- American Academy of PAs in Occupational Medicine (AAPAOM): <http://www.aapaoccmed.org>
- AAPAOM Guidelines about the roles of PAs in occupational medicine: <http://www.aapaoccmed.org/page-770962>

3 – Nurses

Nurses are the face of health care in the United States, providing much of the direct patient care. Occupational Health Nurses (OHNs) often provide health care at worksites. Nursing roles and scopes of practice can be divided into three general categories: Advanced Practice Registered Nurses (APRNs), Registered Nurses (RNs), and Licensed Practical or Vocational Nurses (LPNs and LVNs). Each state’s Board of Nursing has regulations regarding scopes of practice and supervision for all

levels of nurses. These regulations vary from state to state. As with all health care providers, nurses must be licensed in the state where they work. Some nurses have a license to practice in multiple states under the [Nurse Licensure Compact](#).

3.1 – Advanced Practice Registered Nurses

Advanced Practice Registered Nurses (APRNs) are RNs who have further specialized clinical training, have achieved a higher level of education (i.e., a masters or doctoral degree), and have passed the relevant licensure examination. They may have additional areas of specialty delineated by passing the relevant specialty certification. Examples of APRNs include nurse practitioners (NPs), clinical nurse specialists, nurse midwives, and nurse anesthetists. Scope of practice is determined by their specialized training and by the state in which they practice. Many states allow APRNs to practice their profession without being supervised by a physician. In these states, APRNs can independently see patients, perform physical examinations, order labs or other diagnostic studies, diagnose conditions, and develop treatment plans, including prescribing certain medications. Some states require APRNs to have a formal relationship with a physician who provides clinical oversight and is available for consultation if needed. APRNs can obtain national certification by passing a credentialing exam and participating in ongoing continuing education.

3.2 – Registered Nurses

Registered Nurses (RNs) make up the largest segment of the nursing profession, and are frequently the member of the health care team with whom patients have the most interaction. RNs complete either a two-year Associate Degree of Nursing (ADN) program or a four-year Bachelor of Science in Nursing (BSN) program. Both programs include a combination of academic classes and applied work in a clinical setting. Graduates of both pathways are eligible to take the required national licensure examination.

RNs must work under the supervision of a physician or other advanced health care provider, such as an APRN.

Within this supervisory structure, RNs practice nursing care independently, but require medical directives when delivering medications and providing non-nursing interventions. RN scope of practice includes taking health histories, performing physical examinations, making nursing assessments, performing triage, providing patient care, educating patients, and coordinating care.

3.3 – Licensed Practical Nurses and Licensed Vocational Nurses

Licensed Practical Nurses (LPNs) and Licensed Vocational Nurses (LVNs) graduate from a one- to two-year vocational school or training program. LPNs and LVNs can take vital signs, clean wounds, apply bandages, and perform basic patient care. However, in general, their scope of practice does not include triage or clinical decision-making, such as independently determining if an employee is safely able to return to work, or if an employee should be referred to a physician for non-emergency treatment. LPNs and LVNs follow medical protocols and work under the direct supervision of a physician or nurse. Direct supervision means that the supervising RN, APRN, or physician is onsite or readily available for consultation, reviews all patient encounters, and co-signs all patient records.

3.4 – Certified Occupational Health Nurses

Nurses with a certification in occupational health nursing (COHN/COHN-S) have unique training and experience in delivering health and safety programs and services to workers. COHNs can provide direct care to injured and ill employees, serve as case managers for workers' compensation programs, develop and provide occupational safety and health training, and administer an employer's first aid and medical management programs. In industry, COHNs may be part of a multidisciplinary occupational health team, may be contracted as consultants providing a specific service, or may be employed by a company to direct their medical management program.

To become certified in occupational health nursing, RNs or APRNs must successfully complete an academic program in occupational health nursing or have 3,000 hours of experience

in occupational health nursing within the last five years, and pass a national examination administered by the [American Board for Occupational Health Nurses](#).

Additional Resources:

- American Association of Occupational Health Nurses (AAOHN): <http://aaohn.org>
- American Board for Occupational Health Nurses: <https://www.abohn.org>
- National Council of State Boards of Nursing (NCSBN): <https://www.ncsbn.org/index.htm> (has info on the [Nurse Licensure Compact](#))
- [The American Nurses Credentialing Center](#) and the [American Academy of Nurse Practitioners Certification Board](#) certify APRNs.

4 – Other HCPs

A number of other HCPs may be employed onsite to provide occupational health services. The next five sections discuss some of the most common HCPs found at worksites. Although knowledge and clinical skills overlap to some extent, their training and scopes of practice are distinct. Some of the HCPs discussed below can work independently, and some cannot. Almost all require licensing in the state where they practice. The Table at the end of this document provides a succinct overview of these issues.

4.1 – Athletic Trainers

Athletic trainers (ATs) work in collaboration with physicians to prevent and treat sports-related injuries and illnesses. ATs can perform musculoskeletal exams, screen for injuries, design conditioning programs, and in most states, provide care under well-defined protocols. Most ATs work in high schools, colleges, sports (e.g., gyms or professional sports franchises), or health care settings.

ATs may have a bachelor's degree, a master's degree, or a doctorate from an accredited program in athletic training. To become certified, ATs must successfully complete a degree at an accredited program and pass a certifying exam through the [Board of Certification for the Athletic Trainer](#). To maintain their certification, ATs must obtain continuing education annually. All states but California (as of this writing) require that ATs be licensed in the state in which they practice.

Occupational health is an emerging setting for ATs. Companies where jobs require heavy or repetitive physical labor sometimes employ ATs to develop and provide "healthy worker" programs to prevent occupational injuries. Other companies hire ATs to provide first aid and treatment of work-related injuries. When hiring an AT, employers should review their state's laws concerning the scope of practice for ATs. As mentioned above, ATs must be supervised by a physician. Furthermore, some state regulations specify that ATs may provide athletic training services only to *athletes*.

Additional resources:

- National Athletic Trainers Association (NATA):
<https://www.nata.org>
- NATA Code of Ethics: <https://www.nata.org/sites/default/files/nata-code-of-ethics.pdf>
- Commission on Accreditation of Athletic Training Education:
<https://caate.net>
- Board of Certification for the Athletic Trainer:
<http://www.bocatc.org>
 - Quick access to state regulations for ATs:
<http://www.bocatc.org/state-regulation>

4.2 – Chiropractors

Chiropractors treat musculoskeletal injuries and illnesses. They use both traditional medical treatments and chiropractic treatments, such as manipulation and spinal adjustments. To become a Doctor of Chiropractic (DC), chiropractors must complete an undergraduate (bachelor's) degree and then

obtain a post-graduate degree from a program accredited by the [Council on Chiropractic Education](#). Chiropractic education consists of four years (or approximately 4,800 hours) of training in clinical sciences, including supervised training in physical examination, diagnosis, and adjustment techniques. Chiropractors must then pass a licensing exam conducted by the [National Board of Chiropractic Examiners](#) (NBCE).

As with other HCPs, chiropractors must be licensed in the state in which they practice. Chiropractors can practice independently in all states, but chiropractors' scope of practice differs from state to state. For instance, in some states, chiropractors are able to prescribe medications, and in other states, they cannot. Many chiropractors have their own office, but some work in a hospital or multispecialty clinic. Although basic chiropractic training may not include detailed education on work-related injuries and illnesses, the American Chiropractic Association's Council on Occupational Health recommends that chiropractors seeing injured workers obtain postgraduate education in occupational health and ergonomics. The American Chiropractic Board on Occupational Health credentials occupational health training programs for chiropractors.

Additional resources:

- American Chiropractic Association (ACA):
<https://www.acatoday.org>
 - ACA's Council on Occupational Health:
<http://www.acacoh.com/index.html>
- The Council on Chiropractic Education:
<http://www.cce-usa.org>
- National Board of Chiropractic Examiners:
<https://www.nbce.org>
 - Links to state chiropractic licensing boards:
<https://www.nbce.org/links-to-chiropractic-state-licensing-boards>

4.3 – Paramedics and Emergency Medical Technicians

Paramedics and Emergency Medical Technicians (EMTs) are the backbone of the U.S. emergency medical services (EMS) system. The [National Highway Traffic Safety Administration \(NHTSA\)](#) plays a leading role in the EMS system, sets standards for training of paramedics and EMTs, and provides guidance on their scopes of practice. Paramedics and EMTs are trained to provide pre-hospital emergency medical care and transportation to an emergency department (ED) or hospital. Paramedics and EMTs do not practice independently. Rather, they are part of an EMS system and must be supervised by a physician.

Training for basic EMTs and advanced EMTs consists of between 150 to 250 hours of coursework and field experience covering emergency evaluation, treatment, and stabilization of traumatic injuries and critical illnesses, such as heart attacks and strokes. Paramedics have more in-depth education, usually over a 6- to 12-month period. The focus of training for EMTs and paramedics is acute emergency care and stabilization. Their scope of practice does not include diagnosis and treatment of musculoskeletal disorders and other chronic medical conditions.

EMTs and paramedics must pass state examinations to become certified in their profession. They must also obtain continuing education and must be re-certified every two or three years. Certified paramedics and EMTs are licensed by the state in which they practice.

Additional resources:

- [Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions](#)
- The [National Registry of Emergency Medical Technicians](#) oversees and maintains a registry of certified EMTs and paramedics.
- National Highway Traffic Safety Administration publications:
 - NHTSA (2021). [National EMS Scope of Practice Model](#).
 - NHTSA (2009). [National Emergency Medical Services Education Standards](#).
 - NHTSA (2011). [The Emergency Medical Services Workforce Agenda for the Future](#).

4.4 – Physical Therapists and Occupational Therapists

Both physical therapists (PTs) and occupational therapists (OTs) provide hands-on rehabilitation for people who are recovering from a musculoskeletal injury or surgery, or who have certain musculoskeletal or neurologic diseases. PTs and OTs help restore mobility, reduce pain, and improve the function of muscles, joints, and parts of the body such as the back, neck, and extremities. Physical therapy and occupational therapy help people return to work and resume other activities of daily living. PT and OT scopes of practice differ depending on their training and experience.

PTs are trained to diagnose musculoskeletal problems, but PTs are not medical doctors and do not prescribe medication. In the past, PTs received a bachelor's or master's degree in physical therapy. However, new trainees in physical therapy must now complete a Doctor of Physical Therapy (DPT) degree from an accredited program. After an undergraduate college degree, DPT students usually complete a three-year graduate program. PTs must then pass a state-administered national exam. As with other HCPs, PTs are licensed through the state in which they practice. Scope of practice and licensing requirements vary somewhat from state to state. Many PTs work in a health care setting such as a hospital or clinic, where they are supervised by physicians. However, PTs are licensed in most states to practice physical therapy independently. During evaluation and treatment, if PTs identify problems or clinical findings outside their experience or scope, they must refer the patient to another HCP, such as a physician.

OTs complete an undergraduate (bachelor's) degree, followed by a masters or doctorate in OT from a program accredited by the American Occupational Therapy Association. To become certified, OTs must pass a national examination administered by the National Board for Certification in Occupational Therapy. All states require OTs to be licensed in the state in which they are practicing. OTs may provide occupational therapy services independently, but many OTs work as part of a health care team in a hospital, long-term care facility, or clinic. Education, experience, and state law govern an OT's scope of practice.

Both PTs and OTs may supervise physical therapy and occupational therapy assistants and aides. PT and OT assistants and aides with a high school or undergraduate degree cannot practice independently. They provide patient care and treatment under the direction of PTs and OTs.

Appendix II – Additional Background and Operations Considerations

This appendix discusses other important factors that employers should consider before creating an onsite workplace clinic.

Throughout this appendix, the term “onsite workplace clinics” (OWCs) refers to facilities within a plant or workplace that offer health care to workers with work-related symptoms, injuries or illnesses. OWC is a blanket term that encompasses commonly used terms such as “nursing stations,” “health units,” “first aid stations,” and others.

Ancillary Services

Some OWCs provide services unrelated to emergency or acute care of occupational injuries and illnesses. Examples include routine physical examinations, screening laboratory tests, and drug screens. Some OWCs evaluate and treat workers with non-work-related medical conditions, such as high blood pressure or cold symptoms. Others are integrally involved in health promotion and wellness activities and on-site exercise programs. Just as in any community clinic, the structure and staffing of an OWC should be appropriate to the services provided.

Supervision

All OWCs should have an appropriate clinical supervisory structure. A designated, appropriately licensed practitioner, i.e., a physician or APRN, who is licensed to practice medicine without supervision or protocols, should be available for consultation when necessary, such as when a worker has a condition not addressed in written protocols or when the evaluating HCP needs medical advice. Appropriate clinical supervision must be available during all shifts when the OWC operates, including overnight shifts. State laws require clinical supervision of many HCPs (see Chapter 3). The clinical supervisor should be a licensed HCP whose scope of practice includes supervision of subordinate HCPs. Some situations may require that the clinical supervisor be onsite.

Clinical supervision also entails review of medical care and treatment, assessment of skills and competencies, and in many cases, counter signatures though this varies from state to state. For example, a physician or APRN may need to sign all charts and prescriptions written by certain HCPs. As part of the quality management processes, some states require formal retrospective systematic reviews of charts. Clinical supervisors review medical records to determine that documentation is appropriate, and that treatments and diagnostic tests meet professional standards. For instance, drug testing must meet chain of custody requirements. Spirometry must meet validity and reproducibility criteria, and at least for some OSHA standards the technician must have a current training certificate from NIOSH. Clinical supervisors evaluate their staff and ensure that the HCPs have the proper, up-to-date training and certification to perform their job functions. Clinical supervisors may also write, review, and update medical protocols or directives that other HCPs follow.

Clinicians in non-clinical organizations have administrative responsibilities and the associated management chains of command, in teamwork, with training requirements, scheduling, and other obligations. Such administrative performance elements differ from clinical performance and may present conflicts with supervisors. Administrative supervisors without appropriate medical certification and licensure cannot supervise the onsite HCPs; their training and skills generally fail to meet clinical supervision requirements as defined in state licensing laws. The case studies in Chapter 5 illustrate problems that can occur when clinical supervision is inadequate or nonexistent and conflicts with administrative chains of command.

Medical protocols

Medical protocols are written clinical procedures and instructions that HCPs are expected to follow when evaluating specific symptoms or injuries. In an OWC, these protocols should be written, updated, and reviewed at least annually by a supervising OEM physician or APRN. They should be

maintained in a policy and procedures document or manual. At a minimum, medical protocols should address the common symptoms and injuries seen at the facility. Medical protocols should be written for the level of training and scope of practice of the HCPs who use them. For instance, even in non-emergency situations such as a low back strain, some HCPs do not have the training or scope of practice to make judgment calls about when to refer a worker for higher-level evaluation and care. An OWC's medical protocols should ensure that HCPs receive appropriate and clear guidance on when a referral is needed in non-emergency situations, ensuring that the HCPs are not making independent clinical decisions that are beyond their permissible scopes of practice. (Tustin et. al., 2018).

Ongoing Evaluation of Onsite Health Care Services

In the same way that businesses perform regular audits to ensure quality products, health care organizations evaluate the health care provided in their institutions. Frequent evaluations help ensure quality patient care. These evaluation efforts and formal audits of performance are termed "quality assurance" (QA), "quality improvement" (QI), or "performance improvement" (PI). The U.S. Department of Health and Human Services describes QI as the "systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups" (HRSA, 2011). HRSA provides extensive tools and applications (AHRQ, 2019). Similar to the "plan-do-check-act" business approach to quality improvement, QI in health care evaluates actions of the health care team in relation to patient outcomes and patient satisfaction. These regular evaluations, along with evidence-based medical advances, form the basis of positive changes in clinical practice. Future rounds of QI then evaluate the changes.

Occupational health care services should include regular QI evaluations, like any other health care service. Employers with OWCs should consult with an OEM Physician or COHN/COHN-S to develop, conduct, and oversee a QI program.

Confidentiality

Confidentiality is a basic tenet in the ethical practice of health care. OWCs are obliged to maintain the confidentiality of employees' protected health information (PHI). In general, clinics should not share PHI with anyone, including a worker's supervisor or human resource (HR) staff, without the worker's authorization. Employee health records should be kept separate from personnel files. Paper records should be in locked files. Electronic health record systems must restrict access, should be encrypted, and should have audit trails to document who has accessed the system. Failure to follow these principles may put HCP in conflict with their professional ethics standards and present the potential for licensure violations.

Workers with limited English proficiency are entitled to confidentiality in health care encounters. If the HCP does not speak the same language as the employee, then the HCP should use an outside professional medical interpretation service. The use of coworkers, family members, or other company employees to interpret might cause a breach of confidentiality, as workers generally have the right to confidentiality in their medical interactions. Using an untrained non-professional to translate may lead to the transfer of inaccurate information, resulting in incorrect diagnoses, and delaying appropriate recognition and treatment. The Additional Resources section at the end of this appendix provides information about finding a certified medical interpreter.

These basic confidentiality principles have many legal subtleties and some exceptions. Laws that affect the confidentiality of occupational health care include:

- **The Health Insurance Portability and Accountability Act of 1996 (HIPAA).** HIPAA's provisions, and subsequent updates, govern how clinicians and other covered entities should handle PHI; the standards reflect professional codes of ethics even though most employers with OWC are not covered by that Act.
- **The Genetic Information Nondiscrimination Act of 2008 (GINA).** GINA prohibits employment discrimination based on genetic information. In general, employers and health

care providers who make employment decisions, or conduct fitness-for-duty examinations, should not have information about the employee's genetic background or family medical history.

- **The Americans with Disabilities Act (ADA).** ADA contains provisions to protect the confidentiality of medical records obtained during medical examinations that an employer requires after making an offer of employment.
- **Workers' compensation laws.** States regulate workers' compensation insurance. In some cases, confidentiality of PHI might not be guaranteed if the worker files a workers' compensation claim.

A full discussion of the complex legal requirements regarding confidentiality is beyond the scope of this document. OSHA encourages employers to consult a health law attorney to ensure compliance with all applicable state and federal regulations.

Additional Resources:

- **Health Information Privacy** webpage. Office for Civil Rights, U.S. Department of Health and Human Services.
- **Privacy, Security, and Electronic Health Records.** Office for Civil Rights, U.S. Department of Health and Human Services.
- **Improving Patient Safety Systems for Patients with Limited English Proficiency-A Guide for Hospitals.** September 2012, AHRQ Publication No. 12-0041. Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.
- **Revised Appendix A, Interpretive Guidelines for Hospitals. CMS Manual System.** December 2, 2011. Centers for Medicare & Medicaid Services, Department of Health & Human Services.
- **Quality Improvement.** Health Resources and Services Administration, U.S. Department of Health and Human Services.
- **A Report of Findings.** The Joint Commission, 2007.
- **Resources Related to Effective Communication.** The Joint Commission.

- [National Standards of Practice for Interpreters in Health Care](#). September 2005. National Council on Interpreting in Health Care.
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Appendix III – Ethical Concerns

The fundamental purpose of onsite occupational health services, including OWC, should be to promote the health and safety of the workforce. This philosophy reflects the ethical practice of health care, which dates to the Greek physician, Hippocrates. Use of OWC to delay or prevent workers' access to appropriate medical care violates ethical medical and nursing standards of practice and may result in disciplinary action by State licensing authorities. Further, supervisors should not be involved in medical treatment decisions or attempt to influence these clinical decisions for any reason. Additionally, employers should not set broad policies that effect the delivery of care in a manner that conflicts with scope of practice, licensing, and professional ethics.

Although most employers have workers' best interests at heart, OSHA has encountered situations in which onsite workplace clinics failed to adhere to recognized medical and ethical standards. Some clinics denied referrals to physicians, even when workers specifically asked to see a doctor. Some clinics relied on unqualified laypeople, such as co-workers, to provide language interpretation when injured workers did not speak English. Health care providers at some workplace clinics ignored written treatment protocols developed by consulting physicians. As a result, injured workers received deficient health care.

There are many ethical issues in health care. In OSHA's experience, two of the most important ethical concepts that onsite workplace clinics violate are conflicts of interest and beneficence.

Conflicts of interest between clinicians and employers can harm workers and impede proper clinical decision-making. At workplace clinics, the risk of competing financial interests to undertreat is higher than at traditional offsite clinics or hospitals. For example, an employer might establish an onsite clinic to save money by preventing injured workers from visiting an expensive hospital emergency department (ED). An employer might discourage onsite clinical staff from placing injured workers on restricted duty, because such workers are less productive and their medical care costs may increase.

Both scenarios represent financial conflicts of interest. Clinical staff, such as registered nurses with a dependent scope of practice, may report to administrative staff for oversight. They may experience conflict between the administrative demands of their supervisory chain and their clinical, professional judgment, including violating confidentiality requirements.

Beneficence (the dual master conflict): Clinicians practicing occupational medicine may experience conflicts between employers’ requests and good clinical practice. The ethical principle of beneficence states that health care professionals’ primary responsibility is to do good for the patient. The principle of beneficence explicitly prioritizes patient needs and benefits over those of the employer. Clinics and health care providers should always act in the best interests of the patient. Other considerations, such as organizational pressures, financial costs, and business needs, must be secondary.

Other ethical principles that apply to occupational health care include non-maleficence (i.e., Hippocrates’ famous quote “First, Do No Harm”), avoidance of discrimination, respect for workers’ autonomy, and maintenance of confidentiality. For more information about ethical issues that affect onsite workplace clinics, employers and health care providers should consult published ethical guidelines and be familiar with local laws and regulations. General codes of health care ethics are available from several organizations. Examples that are specific to occupational health care include the [Code of Ethics of the American College of Occupational and Environmental Medicine \(ACOEM\)](#), and the [Code of Ethics of the American Association of Occupational Health Nurses \(AAOHN\)](#). Employers should consult Federal and State laws on confidentiality and recordkeeping/documentation requirements. The American Nurses Association has a detailed code of ethics as do the National Athletic Trainers’ Association (NATA) and the National Association of Emergency Medical Technicians. The table below contains detailed information about the Code of Ethics for each type of HCP.

There are important differences between categories of health care providers such as physicians, nurses, and emergency medical technicians. However, the difference between a well- and poorly-performing workplace clinic lies not only in the qualifications of the providers but also in the structures and processes, ethical foundations, and mission of the clinic. Management that allows or encourages workplace clinics to violate ethical standards is problematic, even if the clinic’s health care providers are properly educated, licensed, and credentialed.

Health care professionals should never participate in unethical practices at workplace clinics. Doing so is a disservice to their patients and may put themselves at risk of disciplinary action by state licensing authorities.

TABLE: Comparison of health care professionals: licensing, supervision, training, and scope of practice, where available.

Type of health care professional (HCP)	Licensed to work independently, without supervision or oversight by another HCP?	Is special certification in occupational health available?	Scope of practice	National Association	Code of Ethics
Physician (MD, DO)	Yes	Yes. Some physicians are occupational and environmental medicine (OEM).	Diagnosis and treatment, including prescribing medication. Supervision of other HCPs.	American College of Occupational and Environmental Medicine [Certification by the American Board of Medical Specialties]	ACOEM Code of Ethics
Physician Assistant (PA) [increasingly called Associate]	No	No, but the American Academy of PAs in Occupational Medicine offers special training.	Examination, diagnosis, and patient care as part of a health care team supervised by a physician.	American Association of Physician Associates	16-EthicalConduct.pdf (aapa.org)
Advanced Practice Registered Nurse (APRN)	Yes, in most states. Depends on state law.	Yes. Some APRNs are certified occupational health nurses (COHN/COHN-S).	Similar to physicians		

Type of health care professional (HCP)	Licensed to work independently, without supervision or oversight by another HCP?	Is special certification in occupational health available?	Scope of practice	National Association	Code of Ethics
Registered Nurse (RN)	No	Yes. Some RNs are certified occupational health nurses (COHN/COHN-S).	Medical history and exam; nursing assessments; patient care	American Nurses Association	Code of Ethics for Nurses With Interpretive Statements (View Only for Members and Non-Members) (nursingworld.org)
Licensed Practical or Vocational Nurse (LPN, LVN)	No	Yes. Some RNs are certified occupational health nurses (COHN/COHN-S).	Focused history, exams, and nursing care following protocols	No national organizations	
Certified Occupational Health Nurse (COHN/COHN-S)	Yes, if the nurse is an APRN. No, if the nurse is an RN. No, if the nurse is an LPN/LVN	Yes. COHN/COHN-S are certified by the American Board for Occupational Health Nurses.	Direct patient care for injured and ill employees, workers' compensation case management, development of occupational safety and health training, administration of first aid and medical management programs.	American Board for Occupational Health Nurses	Code of Ethics ABOHN, Inc.
Athletic Trainer (AT)	No	No	Examination, evaluation, and care of sports-related injuries in athletes	National Athletic Trainers' Association	code_of_ethics.pdf (nata.org)
Chiropractor (DC)	Yes	No, but the American Chiropractic Board on Occupational Health offers special training.	Diagnosis and treatment, primarily of musculoskeletal injuries and conditions		Code of Ethics - ACA Today
Paramedic, Emergency Medical Technician (EMT)	No	No	Pre-hospital emergency care and transportation	National Association of Emergency Medical Technicians	EMT Code of Ethics EMS Code of Ethics (naemt.org)
Physical Therapist, Occupational Therapist (PT, OT)	Yes, for at least one month after begin of an incident or injury	No	Examination and rehabilitation of musculoskeletal and neurologic injuries and conditions	American Physical Therapy Association	APTA Web Template

References

- 1) OSHA 29 CFR 1904 <https://www.osha.gov/laws-regs/regulations/standardnumber/1904>
- 2) AHA ARC first aid <https://cpr.heart.org/en/resuscitation-science/first-aid-guidelines/first-aid#:~:text=We%20define%20first%20aid%20as%20helping%20behaviors%20and,by%20anyone%20in%20any%20situation%20and%20includes%20self-care.>
- 3) Letter of interpretation to Charles Brogan, January 16, 2007 <https://www.osha.gov/laws-regs/standardinterpretations/2007-01-16-0>
- 4) Best Practices Guide: Fundamentals of a Workplace First-Aid Program <https://www.osha.gov/sites/default/files/publications/OSHA3317first-aid.pdf>
- 5) Letter of interpretation to David Nakama, N1, 2005. CPR training is a required element in some OSHA general industry standards. [CPR training is a required element in some OSHA general industry standards. | Occupational Safety and Health Administration](#)
- 6) Institute of Medicine. Strategies to Improve Cardiac Arrest Survival: A Time to Act. [IOM-CardiacArrestReportBrief.pdf \(dcric.org\)](#)
- 7) Larsen MP, Eisenberg MS, Cummins RO *et al.*, Predicting survival from out-of-hospital cardiac arrest: a graphic model. *Ann Emerg Med* 1993;22: 1652–1658.

OSHA Assistance, Services, and Programs

OSHA has a great deal of information to assist employers in complying with their responsibilities under OSHA law. Several OSHA programs and services can help employers identify and correct job hazards, as well as improve their safety and health program.

Establishing a Safety and Health Program

Safety and health programs are systems that can substantially reduce the number and severity of workplace injuries and illnesses, while reducing costs to employers.

Visit www.osha.gov/safety-management for more information.

Compliance Assistance Specialists

OSHA compliance assistance specialists can provide information to employers and workers about OSHA standards, short educational programs on specific hazards or OSHA rights and responsibilities, and information on additional compliance assistance resources.

Visit www.osha.gov/complianceassistance/cas or call 1-800-321-OSHA (6742) to contact your local OSHA office.

No-Cost On-Site Safety and Health Consultation Services for Small Business

OSHA's On-Site Consultation Program offers no-cost and confidential advice to small and medium-sized businesses in all states, with priority given to high-hazard worksites. On-Site consultation services are separate from enforcement and do not result in penalties or citations.

For more information or to find the local On-Site Consultation office in your state, visit www.osha.gov/consultation, or call 1-800-321-OSHA (6742).

Under the consultation program, certain exemplary employers may request participation in OSHA's **Safety and Health Achievement Recognition Program (SHARP)**. Worksites that receive SHARP recognition are exempt from programmed inspections during the period that the SHARP certification is valid.

Cooperative Programs

OSHA offers cooperative programs under which businesses, labor groups and other organizations can work cooperatively with OSHA. To find out more about any of the following programs, visit www.osha.gov/cooperativeprograms.

Strategic Partnerships and Alliances

The OSHA Strategic Partnerships (OSP) provide the opportunity for OSHA to partner with employers, workers, professional or trade associations, labor organizations, and/or other interested stakeholders. Through the Alliance Program, OSHA works with groups to develop compliance assistance tools and resources to share with workers and employers, and educate workers and employers about their rights and responsibilities.

Voluntary Protection Programs (VPP)

The VPP recognize employers and workers in the private sector and federal agencies who have implemented effective safety and health programs and maintain injury and illness rates below the national average for their respective industries.

Occupational Safety and Health Training Courses

OSHA partners with more than 25 OSHA Training Institute Education Centers at multiple locations throughout the United States to deliver courses on OSHA standards and occupational safety and health topics to thousands of students a year. For more information on training courses, visit www.osha.gov/otiec.

OSHA Educational Materials

OSHA has many types of educational materials to assist employers and workers in finding and preventing workplace hazards.

All OSHA publications are free at www.osha.gov/publications and www.osha.gov/ebooks. You can also call 1-800-321-OSHA (6742) to order publications.

Employers and safety and health professionals can sign-up for *QuickTakes* or *Información Rápida*, OSHA's free, twice-monthly online newsletters with the latest news about OSHA initiatives and products to assist in finding and preventing workplace hazards. To sign up, visit www.osha.gov/quicktakes.

OSHA Regional Offices

Region 1

Boston Regional Office
(CT*, ME*, MA*, NH, RI, VT*)
JFK Federal Building
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(617) 565-9860 (617) 565-9827 Fax

Region 2

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Region 3

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Region 9

San Francisco Regional Office
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Guam and the Northern Mariana Islands)
San Francisco Federal Building
90 7th Street, Suite 2-650
San Francisco, CA 94103
(415) 625-2547 (415) 625-2534 Fax

Region 10

Seattle Regional Office
(AK*, ID, OR*, WA*)
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20425 72nd Ave South, Suite 150A
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*These states and territories operate their own OSHA-approved job safety and health plans and cover state and local government employees as well as private sector employees. The Connecticut, Illinois, Maine, Massachusetts, New Jersey, New York and Virgin Islands programs cover public employees only. (Private sector workers in these states are covered by Federal OSHA). States with approved programs must have standards that are identical to, or at least as effective as, the Federal OSHA standards.

Note: To get contact information for OSHA area offices, OSHA-approved State Plans and OSHA consultation projects, please visit us online at www.osha.gov or call us at 1-800-321-OSHA (6742).

How to Contact OSHA

OSHA's mission is to assure America's workers have safe and healthful working conditions free from unlawful retaliation. OSHA carries out its mission by setting and enforcing standards; enforcing anti-retaliation provisions of the OSH Act and other federal whistleblower laws; providing and supporting training, outreach, education, and assistance; and ensuring state OSHA programs are at least as effective as federal OSHA, furthering a national system of worker safety and health protections.

For more information, visit www.osha.gov or call OSHA at 1-800-321-OSHA (6742), TTY 1-877-889-5627.

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