Guidance: Public Health Referrals to OSHA

Council of State and Territorial Epidemiologists
Occupational Health Surveillance Subcommittee

September 2011

This document describes factors that state public health departments and their state or federal Occupational Safety and Health Administration (OSHA) partners should consider as they develop plans to improve public health by using public health surveillance data to identify and refer potentially hazardous worksites to OSHA for investigation. The document was developed by the CSTE Occupational Health Surveillance Subcommittee following a workshop on March 9-10, 2011, in Washington DC attended by representatives from state occupational health programs, OSHA and the National Institute for Occupational Safety and Health[1].

Background and Rationale for Public Health/OSHA Collaboration

State public health departments have mandatory responsibilities for monitoring conditions hazardous to the health of the public, including collection of reports of individuals with selected exposures, illnesses or injuries. Reports of persons with work-related illnesses and injuries often are an indication (i.e., a sentinel event) that other persons may be exposed to the same hazardous conditions at work, and thus indicate the need for intervention. Public health has the responsibility to prevent others from becoming ill, injured or over-exposed to hazardous substances, especially those most vulnerable, by mitigating or eliminating hazards; however, health departments often do not have the resources, expertise or access to worksites to fulfill this mandate. Federal and state OSHA programs have the authority and expertise to conduct inspections in worksites. This includes the authority to require employers to comply with workplace standards to reduce health and safety risks. Thus collaboration between public health agencies and OSHA to address workplace hazards through the identification of sentinel cases of illness and injury can be highly effective and efficient. The states that have already established collaboration between their public health surveillance and OSHA programs have demonstrated the value of such collaborations.

[1]This guidance document is a product of the CSTE Occupational Health Surveillance Subcommittee only. OSHA and NIOSH have not contributed to its contents.

Complementary Features of Agency Mandates and Functions That Promote Safety and Health

Public Health	OSHA
Has access to protected health information about individuals because of mandatory disease and injury reporting requirements.	Has access to worksites to enforce OSHA regulations, levy fines and monitor hazard abatement.
Has medical expertise to evaluate and confirm illness and injury in case reports, including severity and causes.	Has technical expertise to evaluate safety and health, including conducting air monitoring and other environmental sampling.
Has the trust of health care providers and has established relationships with multiple stakeholders.	Has established relationships with employers, unions and other stakeholders.
Often has cultural competency skills to work with vulnerable groups such as minorities or immigrants and refugees.	Has developed a variety of approaches to identifying high-hazard industries and worksites. Also has initiated programs for vulnerable populations.
Has capacity to interpret surveillance data to recommend industries and occupations for attention.	Has used inspections to draw attention to an industry and heighten awareness of hazards.
Has local public health networks for disseminating information	Has employer/union based networks for disseminating information.

A public health - OSHA referral system benefits each agency. For public health, OSHA activities demonstrate and expand on the impact public health surveillance has on prevention. For OSHA, identification of high-hazard worksites based on reports of workers with work-related exposure, illness or injury can increase the likelihood of finding hazards over routine inspections driven by targeting or complaints. Thus, public health referrals to OSHA generate high-yield inspections with larger fines and more meaningful impact by identifying conditions that have caused injury or illness and preventing further injuries and illnesses at these worksites. In addition, confirmation by a public health expert of an exposure, injury or illness could be valuable if the employer contests the findings of the inspection. Public health personnel can potentially provide this medical expertise themselves or sometimes can facilitate communication between health-care providers and OSHA.

Establishing procedures for public health referrals to OSHA requires several steps:

Policies and Confidentiality Issues

- The public health agency should review and identify whether legal impediments exist to public health referrals to OSHA, e.g., whether the name of the employer of an ill or injured worker can be given to OSHA. If these legal impediments cannot be overcome then referrals will not be possible. To make referrals to OSHA, public health needs to be able to name the employer but not the ill or injured worker. In some states, personally identifying information is protected and cannot be released without the consent of the individual; employers usually do not have the same level of protection. Another consideration is if there is other information obtained from individual case reports legally considered confidential, e.g., specific blood lead level, which cannot be released. Confidentiality rules may vary by data source (i.e., laboratory vs. hospital records) used to identify the case.

- Public health agencies should determine their policy regarding the need to obtain consent from the injured or ill worker before referring the individual's employer to OSHA. The state health department can use existing policies for conducting infectious disease or sexually transmitted disease investigations to address issues surrounding worker consent for referrals. Requiring consent from an ill or injured worker might be abdicating a public health agency's responsibility to protect others from serious safety and health hazards and states currently making referrals to OSHA have varied approaches.

    - *Some state health departments do not request consent but instead ask the worker about his/her concerns before referring the employer to OSHA and discuss ways those concerns can be allayed. Other states make referrals without contacting the worker. Still others vary their approach according to the perceived seriousness of the report, e.g., blood lead level of 80 µg/dL vs. 25 µg/dL or number of injured workers. States may also decide to use different approaches for different conditions; for example, some states do not make referrals for chronic conditions without talking to the worker but do make an immediate referral for serious traumatic injuries. Regardless of whether consent is acquired, public health agencies should attempt to ensure that referring the employer to OSHA will not jeopardize the worker's job; this is of particular concern in small workplaces. Successful approaches to ensure that no retribution is taken against the worker include delaying the referral and requesting OSHA not identify the source or reason for the referral. However, this approach might conflict with OSHA's intent to investigate an event within 6 months after injury/illness or could be problematic with a transient construction site and will need to be discussed with OSHA.*

Agreements between State Health Departments and OSHA

- The state health department and OSHA leadership should establish personal relationships and share information about agency activities, priorities, legal mandates and constraints. To initiate an understanding/procedure between agencies, the health department should contact the OSHA Regional Administrator (rather than a duty officer). The OSHA Regional Administrator might involve directors of the area offices within their regions. In states with state OSHA plans, public health should contact the director of the state OSHA plan (who will be a state official). Twenty-seven states administer their own OSHA-approved occupational safety and health programs, or state plans. See the State Programs section of OSHA's Web site, http://www.osha.gov/dcsp/osp/index.html.

- The state health department and OSHA should agree about what type of events will be referred to OSHA, when and how the referrals will be made (i.e., phone, email, fax or letter), how OSHA will respond and what information OSHA will share with the state agency. For example, state public health agencies conducting surveillance need feedback from OSHA about investigation outcomes such as whether hazards were identified and standards violated. Some states conducting surveillance also like to know whether OSHA already knew about the incident before the referral. Both OSHA and state health agencies can use this information to assess the impact of their collaboration (see below: evaluating referrals).

- The state health department should determine whether a written memorandum of understanding (MOU) or a less formal agreement should be put in place to establish procedures.

- *States agencies that make OSHA referrals have various understandings with their OSHA programs; a formal written document is not always required to make referrals to OSHA. MOUs have advantages and disadvantages. They can be useful to both the state agency and OSHA; they detail the protocols for referrals; specify criteria for different conditions; provide points of contact; and specify whether the health department investigator can accompany the OSHA compliance officer, which department of health receives the inspection report and how information will be shared. OSHA protocols to protect worker confidentiality should be included (see below). The agreements can stand until both parties decide to end them, avoiding new negotiations with each change of administration. Disadvantages can include delays in initiating cooperation depending on who in each agency has to review before signing the document.*

- *A less formal document that outlines the protocol and each agency's expectations and actions and on which frontline supervisors agree might be a better approach in some states. (See Appendix 1 for copies of MOUs used by Alabama and New Jersey.)*

Referral Procedures

Regardless of whether an MOU or a less formal agreement is put in place, the following topics should be addressed between the state health department and OSHA (summarized in Table I).

- **Criteria for referral**

  - The referral should be timely, i.e., within 6 months of the exposure or injury incident. OSHA generally will not conduct inspections for referrals made later than 6 months after the exposure or incident. State health departments should clarify with OSHA in what situations OSHA still might want a referral even if more than 6 months after the event.
  - The incident should be confirmed. Public health agencies should have reliable evidence that the exposure, illness, or injury occurred at a specific site and was indeed work-related. A referral to OSHA should not be based on poorly documented, anecdotal, or hearsay events. However, in the interest of timeliness, OSHA may want the referral before the state agency has completed its confirmation process.
  - Public health agencies need to be sure that the employer falls under OSHA jurisdiction. Both federal OSHA and state plan OSHA do not cover mines or self-employed persons. Whether a state has an OSHA state plan or is covered by federal OSHA also affects jurisdiction—federal OSHA does not cover state, county or municipal employees; OSHA state plans do not cover the Merchant Marine or federal employees (Table II). Because jurisdictions might not always be clear (i.e., whether the injured worker is an independent contractor [self-employed] or an employee), health departments should review referrals with their OSHA liaison when jurisdictional issues exist.
  - The hazard causing the illness or injury should be serious—and the meaning of "serious" needs to be agreed on in advance by the state health department and OSHA.
  - Having an ill or injured worker related to a work condition for which OSHA has a standard (e.g., elevated blood lead level, work-related amputation) is preferable when referrals are initiated. With more experience working together, effective referrals from health departments for conditions, such as work-related asthma, for which OSHA might not have a standard, can be equally useful. (An OSHA state plan state also might have additional or different standards from federal OSHA.)
  - The state agency should understand OSHA's local, regional and national priorities. OSHA does not have the resources to accept an unlimited number of referrals, and the conditions and number to be referred should be agreed on so the state agencies and

OSHA can maximize the benefit obtained from these referrals. Important questions to address are which types of referrals will be inspected and which will receive a letter?
  - There may be times when a referral to OSHA has the potential to jeopardize a good working relationship between the health department and the health-care provider who reported the illness or injury (i.e., a physician who works for the employer or a clinic providing services to the employer). The state agency needs to balance whether the health-care provider can effect change to protect other workers without outside intervention versus the working relationship that the state health department has developed with the health care provider.

- **Elements of the referral**

  - Determine how referrals to OSHA will be made (fax, email, telephone, mail) and to whom.
  - Specify what information will be provided to OSHA. At a minimum, it should include the site[2] where the injury or illness occurred, the suspected hazard, the resulting illness or injury, the date(s) of illness onset or injury and any other information about the specific location of the hazard at the site. For an illness or injury at a construction site, the public health agency should specify when possible whether the site is still active.
  - Specify confidentiality provisions. Public health and OSHA need to protect the confidentiality of the name and contact information of the exposed, injured or ill worker about whom the referral is made and the name of individual(s) associated with the worksite. Some states have requested that the health department never be listed as the reason for referral; others always want to be listed; and some vary according to what they believe will best protect the worker from retribution.

- **Conduct of the OSHA inspection**

  - Determine whether a public health liaison can accompany an OSHA inspector on site visits.

    - *In one state, New Jersey, the MOU specifies that federal OSHA area office staff notify the New Jersey Department of Health and Senior Services (NJDHSS) when an inspection is scheduled. If the NJDHSS liaison is available at the scheduled time, then he/she accompanies the OSHA compliance officer on the inspection. If the employer refuses to allow NJDHSS staff on site, the OSHA compliance officer continues the inspection without NJDHSS.*
    - *In some instances (e.g., infectious diseases), the state health department might conduct its own epidemiologic investigation or might conduct an investigation in conjunction with a local health department. The health department(s) and OSHA might jointly investigate the exposure, illness or injury, and share information; in that instance, procedures or a protocol should be established in advance of the investigation to ensure the process can be clearly described to the employer and workers involved.*

[2]The actual physical site address is important, especially for a construction company. Do not give only the employer name; some employers have multiple sites and an office headquarters far from the sites, and the address of the office headquarters is of no use in a site-specific inspection.

- Establish procedures for providing written information to the state health department about the inspection. To ensure the public health issue is addressed and to evaluate the impact of its surveillance program, the health department needs the results of the OSHA-conducted investigation. Possibilities for how and when information goes to public health include 1) OSHA routinely sends completed reports to the state health department; 2) the health department and OSHA sign a "sharing letter" that allows a health department staff member to review the notes of the OSHA inspector as long as the health department keeps the information confidential; 3) a health department staff member accompanies the OSHA inspector on the investigation. Some states may want to incorporate all three approaches. At a minimum, because an investigation report is publicly available after completion, health department staff (or anyone else) can obtain it through a freedom of information request. States might in turn share publicly available OSHA findings with the reporting health-care provider or directly with the worker. Although the provider or worker can directly obtain these documents, sending the report to the provider gives the health agency the opportunity to provide feedback to the provider, thank him/her for reporting and encourage him/her to continue to report. Because providers generally do not know how to obtain a copy of the OSHA report, they appreciate the feedback from the health department.

- **Evaluating referrals**

  - OSHA and state health agencies need to document the positive impact of their work on occupational safety and health. They also need to know whether referrals for some conditions are more useful and productive than others (e.g., amputations vs. work-related asthma vs. elevated blood lead levels). State public health agencies should track referrals and responses (Table III) and periodically meet with OSHA leadership to review what is and what is not working.
  - Successes in the collaboration between OSHA and the public health agency need to be disseminated. Both agencies should be involved in preparing and reviewing reports or publications that describe the program or results of noteworthy worksite investigations.

- **Building working relationships with OSHA**

  - State public health personnel should maintain a good working relationship with Federal OSHA regional administrators, area directors and staff, or the State OSHA plan Director, regional managers and staff in their states. Strategies can include annual meetings with OSHA leadership and staff to review referrals and update priorities, inclusion of multiple OSHA staff on public health agency mailing lists, public health visits to OSHA-area office when there are staff changes and inclusion of an OSHA representative on the public health program advisory board.

- **Referring employers to the OSHA consultation program rather than the enforcement program**

  The OSHA consultation program is a free consultation service staffed by state employees but largely funded by OSHA. Employers must request a consultation. The consultation program will identify potential hazards at their worksites and make recommendations to improve occupational safety and health management systems. Employers who use the consultation program may qualify for a one-year exemption from routine OSHA enforcement inspections. A list of the state consultation programs can be found at https://www.osha.gov/dcsp/smallbusiness/consult_directory_text.html. In the first quarter of 2011, 54% of companies that had consultant visits had less than 26 employees, 32% had 26 to 100, 12% had 101 to 250 and 2% had more than 250 employees.

  - A state public health agency cannot refer an employer to the OSHA consultation program but can suggest that the small business owner request an OSHA consultation. Such consultations can be useful in circumstances in which the health department identifies small businesses that need assistance but do not consider the situation immediately hazardous or receive assurance from the small business that it will request an OSHA consultation. Because the OSHA consultation program has confidentiality requirements, OSHA cannot share any information with health departments about consultations, including whether they were performed. The state health department learns whether an investigation was performed and the results only if the small business voluntarily provides that information to the state health department.

Conclusions

Referrals by state health departments of individual cases of work-related injuries and illnesses to OSHA will ensure that, despite limited resources and/or lack of legal authority at the state health department to effect workplace changes, effective prevention action will be initiated. This document outlines the issues a state health department will want to consider to increase the impact of their occupational health surveillance activities to prevent additional work-related injuries and illnesses.

Table I. Factors a State Can Consider in Making a Referring an Exposure, Illness, or Injury to OSHA

Seriousness of hazard, injury or illness
Other workers at risk
Existence of a confirmed case, i.e., injury or illness
Timeliness
OSHA jurisdiction over worksite; relevant OSHA standard is preferable but not essential; OSHA can also cite under their general duty clause
OSHA priorities (e.g., special emphasis or high-hazard programs)
Confidentially of individual/fear of reprisal
Trust of reporters
Number of referrals to which OSHA will respond in a year
State-initiated investigation/research for which the state has agreed not to share information with an enforcement agency

Table II. Federal OSHA and State OSHA Plan Jurisdiction*

Workplace/worker	Federal OSHA Jurisdiction	State OSHA Plan Jurisdiction
Private sector	29 states	21 states, Puerto Rico and Virgin Islands
State, county and municipal workplaces	No states	25 states†, Puerto Rico and Virgin Islands
Self-employed worker	No states	No states
Railroad	29 states but only if hazard in maintenance garages; all hazards on rails not covered	21 states, Puerto Rico and Virgin Islands covering the private sector but only if hazard in maintenance garages; all hazards on rails not covered
Federal workers	All states	No states
Mines‡	No states, although certain excavations where material not removed from mine are covered	No states, although in 21 states, Puerto Rico and Virgin Islands covering the private sector certain excavations where material not removed from mine are covered
Maritime including Merchant Marine, shipyards and longshoremen	All states	Only four states (CA, MN, VT and WA) cover private sector shore side maritime activities

*Determining jurisdiction can be complicated. This table is only meant as an overview, and the state health departments should consult with OSHA.

†In 4 states (Connecticut, Illinois, New Jersey and New York) the OSHA state plan only covers only nonfederal public employees.

‡Mines, including quarries and sand pits, are covered by the Mine Safety and Health Administration (MSHA) in all states.

Table III. Possible Data to Collect for Tracking and Evaluating the Effectiveness of Referrals

Case identification
Injury/illness
Employer name • Name • City • ZIP code
Referral agency (e.g., OSHA [area office], state agency)
Whether OSHA knew about this injury or illness before the referral
Date of referral
Action taken • Letter to company asking them to address the injury/illness • Site visit • Both • Neither (may include reason, e.g., company not found, not OSHA jurisdiction)
Date of action
• Outcome of site visit (if any) • Citations • Citations related to injury or illness • Fines • Letter of significant findings • Letter of significant findings consistent with injury/illness
Assessment by OSHA of referral
Assessment by health department of referral

APPENDIX I

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MEMORANDUM OF UNDERSTANDING

Between

U.S. Department of Labor Occupational Safety and Health Administration

And

The Alabama Department of Public Health

This Memorandum of Understanding is entered into by and between the **U.S. Department of Labor, Occupational Safety and Health Administration (OSHA)** and the **Alabama Department of Public Health, (ADPH)**.

WHEREAS, this Memorandum of Understanding (MOU) is to formalize a working relationship between ADPH and OSHA to reduce work-related illnesses from lead exposure and to assure a safe and healthful workplaces**.**

WHEREAS, ADPH agrees to inform OSHA of workplaces where employees have blood lead levels (BLLs) that equal or exceed 25 µg/dL of whole blood**.**

THEREFORE, ADPH and OSHA will use the resources of each agency to effectively and efficiently identify and regulate hazardous workplaces. Through this cooperative effort, the goals of each agency to reduce work-related illnesses and injuries will be enhanced.

BACKGROUND

In 1970 Congress passed the Occupational Safety and Health Act to assure safe and healthful working conditions for working men and women. This act established the Occupational Safety and Health Administration (OSHA) and authorized it to promulgate and enforce workplace health and safety standards. Inspections are conducted by OSHA compliance officers to determine employers' compliance with the OSHA standards. These inspections are initiated as a result of fatalities, worker complaints and referrals. Follow-up inspections are conducted to assure corrective actions of violations that are considered to be of high severity. The agency also conducts inspections under National, Regional and Local emphasis programs. These programs are designed specifically to address certain recognizable hazards in the workplace. OSHA has a national emphasis program and Region IV has a regional emphasis program for lead in the workplace. Due to their toxicity OSHA has substance specific standards for several metals including lead, which is, regulated under 29 CFR 1910.1025.

Pursuant to Chapter 420-4-1 Notifiable Diseases of the ADPH Division of Disease Control Administrative Code, the State of Alabama requires that the State or County health department be notified in writing when a person is diagnosed with a blood lead

level (BLL) ≥ 10 µg/dL. The state of Alabama participates in the National Institute for Occupational Safety and Health (NIOSH) Adult Blood Lead Epidemiology and Surveillance (ABLES) Program which requires that the state provide NIOSH BLLs results ≥10 µg/dL for adults (16 years or older).

PROCEDURE

ADPH will refer workplaces where employees have BLLs ≥ 25 µg/dL of whole blood to the OSHA Region IV Regional Administrator. The contact information is as follows:

U. S. Department of Labor – OSHA
Attn: Office of Enforcement Programs
Sam Nunn Atlanta Federal Center
61 Forsyth Street, SW, Room 6T50
Atlanta, Georgia 30303
Work: (404)562-2300
Fax: (404) 562-2295

Every two months ADPH will provide OSHA a report with BLLs results ≥ 25 µg/dL grouped into 3 subgroups: 25-39, 40-59 and ≥60 µg/dL. The report will include the industry and the name of the employer for each referral. However, ADPH shall not refer any information in instances where the release of that information could reasonably violate their state laws or terms of their agreement with OSHA, nor will they release confidential information, unless ADPH has permission from that worker to release such information. OSHA will maintain the confidentially of employees noted in any referral made.

Upon receipt of ADPH referrals, the OSHA Region IV Office will evaluate the referral and transfer it to the appropriate Area Office. The Area Office will schedule an inspection of the facility in accordance with agency policy and procedures. OSHA will provide ADPH a copy of any citations issued to the employer as a result of a referral. Once the inspection case file is closed, OSHA will provide ADPH additional information such as lead monitoring results and employer's abatement actions if ADPH desires such information.

OSHA and ADPH agree to cooperate as fully as the state's laws allow in achieving the goals of this MOU.

EVALUATION

This agreement shall be evaluated one year from the date signed to determine its effectiveness. Appropriate changes, if necessary, may be made at that time, with the mutual consent of both parties.

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PERIOD OF AGREEMENT

This MOU shall continue in effect until modified in writing by mutual consent of both parties or terminated by either party upon thirty (30) days advance written notice to the other.

This MOU does not preclude either party from entering into other agreements to handle special programs, which must be processed separately.

OSHA hereby indemnifies and holds harmless the State of Alabama, ADPH and their officers, agents, servants and employees from any and all claims arising out of acts or omissions committed by OSHA or any of its employee while in performance hereunder.

The rights, duties, and obligations arising under the terms of this Memorandum of Understanding shall not be assigned by any of the parties hereto without the written consent of all other parties.

Effective Date: January 2, 2011

Expiration Date: The **MOU** will terminate on January 2, 2012, unless both parties mutually agree to an extension.

U.S. Department of Labor-Occupational Safety and Health Administration

Signed: _____
Cindy A. Coe
Regional Administrator

Date: 12/9/2010

Alabama Department of Public Health
This Memorandum of Understanding has been reviewed as to content

Signed: _____
Charles H. Woernle, M.D., M.P.H.
Assistant State Health Officer for
Disease Control and Prevention

Date: 12/2/10

APPROVED AS TO FORM AND COMPLIANCE WITH APPLICABLE RULES AND REGULATIONS DEPT. OF PUBLIC HEALTH

DEC 22 2010

OFFICE OF GENERAL COUNSEL

APPROVED
Alabama Department of Public Health

Signed: _____
Donald E. Williamson, M.D.
State Health Officer

Date: 1/14/11

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MEMORANDUM OF UNDERSTANDING ON CADMIUM
BETWEEN
U.S. DEPARTMENT OF LABOR
OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION
AND
NEW JERSEY DEPARTMENT OF HEALTH
OCCUPATIONAL HEALTH SERVICE

I. Purpose:

The purpose of this Memorandum of Understanding on Cadmium (MOUC) is to formalize a working relationship between the New Jersey Department of Health, Occupational Health Service (NJDOH-OHS), and the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) to reduce work related illnesses and to assure safe and healthful workplaces.

This agreement describes the procedure used by the New Jersey Department of Health to inform the U.S. Department of Labor, Occupational Safety and Health Administration, of workplaces where exposures to cadmium may result in systemic cadmium poisoning of employees, and it describes OSHA's use of such information.

A coordinated effort between the New Jersey Department of Health, Occupational Health Service, and the U.S. Department of Labor Occupational Safety and Health Administration, will utilize the resources of each Agency and in combination will more effectively identify and regulate hazardous workplaces.

Through this cooperative effort, the goals of each Agency to reduce work-related illnesses and to assure safe and healthful working conditions will be met.

II. Background:

Cadmium is a systemic poison which effects the urinary and respiratory systems. There are many individuals employed in the State of New Jersey in various job capacities who are exposed to this toxic metal.

The Occupational Health Surveillance Program of NJDOH-OHS collects and analyzes data from various sources and uses these data to implement intervention activities to reduce work-related illnesses, injuries and hazards.

Pursuant to NJAC 8:44-2.11, laboratory supervisors in the State of New Jersey must immediately report to NJDOH results of laboratory examinations which indicate levels of cadmium $\geq$ 10 ug/L blood and $\geq$ 5 ug/L urine. In addition, pursuant to NJAC 8:57-3.1, hospitals who attend any person ill with cadmium toxicity must report the case to NJDOH within 30 days.

In accordance with Sec. 6 of the Occupational Safety and Health Act of 1970, OSHA promulgated comprehensive standards on cadmium, 29 CFR 1910.1027 for general industry, 1928.1027 for agriculture, 1915.1027 for shipyards, and 1926.63 for construction. These standards address the methods to evaluate and control employee exposure to cadmium and establishes a new eight hour Time Weighted Average (TWA) permissible exposure limit for cadmium which is not to be exceeded.

In order to carry out the purposes of the Occupational Safety and Health Act, the Secretary of Labor is authorized to enter, in accordance with established inspection procedures, any workplace or location where work is performed by any employee of an employer; and to inspect and investigate any such place of employment and all pertinent conditions. If, upon inspection or investigation, the Secretary or his authorized representative believes that an employer has violated any regulations prescribed pursuant to OSHA, he shall issue a citation to the employer.

III. Procedure:

The New Jersey Department of Health will refer to the U.S. Department of Labor, Occupational Safety and Health Administration the names and locations of workplaces where the presence of a potential harmful exposure to cadmium is suspected. The referral will include information based on one or more of the following: cadmium blood urine analyses, physician examinations, employee and employer interviews, and any other relevant information received by the NJDOH which indicates possible harmful exposures to cadmium exist.

OSHA will evaluate and process the referrals as per instruction in the Field Operations Manual. OSHA will provide written documentation of the results of the investigation to the New Jersey Department of Health, Occupational Health Service on any investigation initiated as a result of a referral. OSHA agrees not to disclose the source of the referral to the employer.

Period of Agreement:

This MOUC shall continue in effect indefinitely, unless, and until, modified in writing by mutual consent of both parties or terminated by either party upon 30 days advance written notice to the other.

This MOUC does not preclude either party from entering into separate agreements setting forth procedures for other programs which can be addressed more efficiently and expeditiously by special agreement.

James W. Stanley
Regional Administrator
U.S. Department of Labor
Occupational Safety and Health
Administration

Region II

Date: July 26, 1993

Bruce Siegel, M.D., M.P.H.
State Commissioner of
Health
State of New Jersey
Department of Health

Date: 8/20/93

MEMORANDUM OF UNDERSTANDING ON CADMIUM
BETWEEN
THE NEW JERSEY DEPARTMENT OF HEALTH
OCCUPATIONAL HEALTH SERVICE
AND THE
U.S. DEPARTMENT OF LABOR
OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

SUBJECT: Protocol for Implementation of the Memorandum of Understanding on Cadmium (MOUC)

A. Purpose: This instruction provides guidelines for implementing the Memorandum of Understanding on Cadmium (MOUC) between the New Jersey Department of Health - Occupational Health Service (NJDOH-OHS) and the Occupational Safety and Health Administration (OSHA).

B. Scope: This instruction applies to all New Jersey Area Offices and the New Jersey Department of Health, Occupational Health Service.

C. Action: The Area Directors of the New Jersey Area Offices shall ensure that the objectives of the MOUC are effectively implemented in accordance with these instructions.

D. Background: The MOUC continues the established working relationship between the NJDOH-OHS and OSHA. A coordinated effort between the two agencies will utilize the resources of each agency and in combination will more effectively identify and regulate hazardous cadmium locations. NJDOH-OHS will transmit referrals to OSHA relating to indications of high cadmium exposure among New Jersey employees.

E. Guidelines:

1. Transmission of Referrals

a. NJDOH-OHS will transmit a referral to the appropriate New Jersey Area Office when information is obtained through the agency's Health Surveillance Program, that potential violations of the OSHA Cadmium Standards (29 CFR 1910.1027 for general industry, 1928.1027 for agriculture, 1915.1027 for shipyards, and 1926.63 for construction) may exist in the workplace. The following criteria will be considered in selecting the workplaces for referral:

- Cadmium health effects reported;

- Number of employees with blood cadmium levels above 15ug/lwb constituting possible serious cadmium related hazards or blood Cadmium levels above 5ug/lwb constituting possible other-than serious cadmium related hazards;

- Number of employees with urine cadmium levels above either 15ug/L or 15ug/g Cr (depending on the units reported) for possible serious cadmium related hazards, and 3ug/L or 3 ug/g Cr (depending on the units reported) for possible other-than-serious cadmium related hazards;

- Degree of elevation above these levels;

- Employee(s) required to be medically removed have not been removed;

- Violations of OSHA cadmium standards likely;

- Exposure levels known to exceed the PEL;

- History of non-cooperation with NJDOH;

- Cadmium in use and employees potentially exposed without air sampling and/or biological monitoring being performed;

- Employer or employee interviews which describe or indicate poor industrial hygiene practices in the workplace;

- Any other relevant information which may identify cadmium related hazards to employees.

b. All referrals will be submitted in writing. In cases where immediate action should be considered, the initial referral shall be made by the NJDOH-OHS via telefax, if possible, or by telephone with a follow-up in writing within three (3) working days.

c. Referrals submitted should contain the following information, when available:

Establishment:

Site Address:

Mailing Address:

Contact Name: If there are employer/employee contacts, include the names of the individuals.

Hazard Description: List and describe as appropriate, the hazardous process, the duration, location, frequency of eposure, information on controls, personal protective equipment, employees comments relating to exposure, tests conducted and results (without personal identifiers), current health status of adversely affected individuals, and specific locations or departments where hazards exist.

d. In workplaces where OSHA has independently initiated a cadmium inspection, the NJDOH-OHS agrees to provide the information listed in paragraph 1(c) upon request, if available.

2. Receipt of Referrals

a. Upon receipt of a referral, the OSHA Area Office will evaluate the information submitted. Classification of the hazards and inspection scheduling will be done in accordance with instructions provided in the Field Operations Manual.

b. The NJDOH-OHS will simultaneously forward a copy of the referral transmitted to the Area Office to the Regional Office. Correspondence should be addressed to:

U.S. Department of Labor - OSHA
Assistant Regional Administrator
Federal and State Operations
201 Varick Street - Room 670
New York, New York 10014

Telephone: (212) 337-2338
Fax: (212) 337-2371

c. The OSHA Area Office will acknowledge receipt of the referral in writing within three (3) working days.

d. When the OSHA Area Office staff has scheduled a date for initiation of an inspection, the liaison for the NJDOH-OHS shall be contacted. If available, the liaison may accompany the compliance officer on the inspection. An inspection will not be postponed if the liaison is not available at the scheduled time.

3. Inspection Procedures

a. If upon arrival to the site, right of entry of the NJDOH liaison is an issue, the liaison shall follow established NJDOH procedures for refusal. The OSHA compliance officer shall continue the inspection in accordance with established OSHA criteria as instructed in the Field Operations Manual.

b. During the opening conference, the compliance officer shall inform the employer that the investigation was initiated as a result of a referral from a government agency. As per Field Operations Manual instructions, the employer shall not be provided with a copy of the referral. The compliance officer shall not identify the NJDOH as the referring agency.

c. During the course of the inspection, the OSHA compliance officer shall be responsible for all OSHA related activities. The NJDOH-OHS liaison may observe all such activities.

4. Post Inspection Procedures

a. Following completion of cadmium inspections initiated as a result of this program, the area office shall transmit copies of all citations when issued to the liaison for the NJDOH-OHS.

b. If requested, the NJDOH-OHS may obtain redacted copies of inspection case files in accordance with the requirements of the Freedom of Information Act.

c. Release of unredacted case files or case files for inspections which have not been closed will be done on a case by case basis in accordance with established OSHA procedures and based on the Department of Labor Solicitor's Office direction.

5. Confidentiality

a. Each agency agrees to keep all confidential documents exchanged in locked file cabinets. The information will be treated with the same confidentiality restrictions as medical information. This information will not be released without prior approval by the OSHA Area Director and the Director of the NJDOH Occupational Health Service.

6. Liaison and Contact Persons

a. The NJDOH-OHS designated liaison is Ms. Eileen Senn. All correspondence from OSHA will be directed to Ms. Senn at CN 360, Room 701, Trenton, NJ 08625-0360, (609) 984-1863. In her absence Mr. Donald Schill will substitute as liaison.

b. The Area Director in the OSHA Area Office will be the contact person for the U.S. Department of Labor/OSHA. All inquiries relating to a specific establishment or referral shall be addressed to the Area Office which has jurisdiction.

c. General inquiries such as clarification or amendments to the MOUC shall be addressed to the Regional Office. Attached in Appendix A is a listing of the Area Offices and their respective areas of jurisdiction.

Appendix A

Avenel Area Office
U.S. Department of Labor - OSHA
Plaza 35, Suite 205
1030 St. Georges Avenue

Avenel, New Jersey 07001

Telephone: (908) 750-3270
Telefax: (908) 750-4737

Dennis Gaughan, Area Director

Hunterdon, Middlesex, Somerset, Union, Warren, Richmond (Staten Island)

Michael Yarnell
Asst. Area Director for Health

Ron Frye
Asst. Area Director for Health

Hasbrouck Heights Area Office
U.S. Department of Labor - OSHA
500 Route 17 South, 2nd Floor
Hasbrouck Heights, New Jersey 07604

Telephone: (201) 288-1700
Telefax: (201) 288-7315

Efraim Zoldan, Area Director

Bergen, Passaic

Lisa Levy
Asst. Area Director for Health

Marlton Area Office
U.S. Department of Labor -OSHA
Marlton Executive Park
701 Route 73 South
Building 2, Suite 120
Marlton, New Jersey 08053

Telephone: (609) 757-5181
Telefax: (609) 757-5087

Harry Allendorf, Area Director

Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester Mercer, Monmouth, Ocean, Salem

Charles Jenkins
Asst. Area Director for Health

Parsippany Area Office
U.S. Department of Labor - OSHA
299 Cherry Hill Road
Suite 304
Parsippany, New Jersey 07054

Telephone: (201) 263-1003
Telefax: (201) 299-7161

Essex, Hudson,
Morris, Sussex

Robert D. Kulick, Area Director

David Ippolito
Asst. Area Director
for Health

OSHA Regional Office
U.S. Department of Labor - OSHA
201 Varick Street - Room 670
New York, New York 10014

Telephone: (212) 337-2338
Telefax: (212) 337-2371

All Area Offices in
New York, New Jersey

James W. Stanley
Regional Administrator

Anthony DeSiervi
Assistant Regional Administrator
for Federal and State Operations

New Jersey Department of Health
Occupational Health Service
CN 360, Room 701
Trenton, New Jersey 08625-0360

Telephone: (609) 984-1863
Telefax: (609) 984-2218