



COMMONWEALTH of VIRGINIA
DEPARTMENT OF LABOR AND INDUSTRY

C. Ray Davenport
COMMISSIONER

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DRAFT AGENDA

SAFETY AND HEALTH CODES BOARD MEETING

Tuesday June 29, 2021 Emergency Electronic meeting

This date is tentative and subject to change.

9:15 a.m.

******Refer to the Third and Fourth Page of the Agenda for Instructions on Registering to Make Public Comment and Virtual Meeting Access Information******

1. **Call to Order**
2. **Approval of Agenda**
3. **Opportunity for the Public to Address the Board on the issues pending before the Board today, as well as any other topics that may be of concern to the Board and within its scope of authority.**

This will be the only opportunity for public comment at this meeting. Remarks will be limited to 5 minutes in consideration of others wishing to address the Board.

NOTE: Any proposed changes to or proposed revocation of the Final Permanent Standard (FPS), for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19 16VAC25-220 voted upon by the Safety and Health Codes Board at its upcoming meeting will go through a similar notice and comment process to that used for adoption of the FPS. This includes a written comment period for the public and stakeholders to provide written feedback to the Board about the proposed changes or proposed revocation, at least one public hearing, and development of an Economic Impact Analysis (EIA). The Board will then hold a second meeting and vote to accept or reject the proposed changes or proposed revocation as final. During both the proposed and final change stages, the Governor will have the opportunity to review the changes per 16VAC25-220-20.A.

4. **New Business**
 - a) Consider for adoption OSHA's Occupational Exposure to COVID-19, Emergency Temporary Standard (COVID-19 ETS), 1910.502, et. seq.

Presenter – *Jay Withrow*

- b) Proposed Amendments to the Final Permanent Standard (FPS), for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-22.

c) *(If requested by the Board)* Closed Meeting for the Purpose of Consultation with Legal Counsel Regarding Specific Legal Matters Pursuant to § 2.2-3711.A.8 of the Code of Virginia

5. **Items of Interest from the Department of Labor and Industry**
6. **Items of Interest from Members of the Board**
7. **Meeting Adjournment**

PUBLIC PARTICIPATION

Members of the public may listen to the meeting via the Cisco WebEx platform by using the weblink, access code, and password below, or audio conference only by using the telephone numbers and access code below.

Participation capacity is limited and is on a first come, first served basis due to the capacity of CISCO WebEx technology.

Event address for attendee:

<https://covaconf.webex.com/covaconf/onstage/g.php?MTID=e14676da4c9945614539503cf88db9bee>

Event number (access code): 161 859 8342

Event password: DOLI2021

To join the audio conference only:

Call this number: 1-517-466-2023 or **US Toll Free** 1-866-692-4530

Enter this Access Code: 161 859 8342

If you wish to make an Oral Public Comment during the “Opportunity for the Public to Address the Board” period of this meeting, you must follow the instructions below:

- Oral public comment will be received from those persons who have submitted an email to **Princy.Doss@doli.virginia.gov** no later than **12:00 PM (NOON)** on **June 28, 2021** indicating that they wish to offer oral comment. Comments may be offered by these individuals when their name is announced by Ms. Doss. Oral comments will be **restricted to 5 minutes** each.
- When logging onto WebEx each person **must provide their full name** during the registration process upon entering the meeting. Do not use the default username as it is imperative that the meeting organizer be able to determine who is in attendance based on their registration name. Failure to follow these specific registration instructions will restrict your ability to participate with oral remarks.
- If you wish to make an oral comment and will be utilizing the “audio conference only” option to witness the hearing, **you must provide the phone number you will be calling in from in your email to Ms. Doss** so that the administrator will know whom to unmute at the appropriate time.
- Other important information:
 - All parties will be muted until Ms. Doss announces the name of the person who is next to provide an oral comment.

- All public participation connections will be muted following the public comment periods.
- Please login from a location without background noise.
- Individuals participating in the Virtual meeting on June 29, 2021 are encouraged to submit a written version of any comments by email to **Princy.Doss@doli.virginia.gov** no later than **5:00 PM on June 30, 2021.**

Should any interruption of the broadcast of this meeting occur, please call 804-371-2318 or email **Brian.Jaffe@doli.virginia.gov** to notify the agency. Any interruption in the broadcast of the meeting shall result in the suspension of action at the meeting until repairs are made and public access is restored.

FOIA Council Electronic Meetings Public Comment form for submitting feedback on this electronic meeting may be accessed at:

<http://foiacouncil.dls.virginia.gov/sample%20letters/welcome.htm>



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DRAFT: JUNE 24, 2021

Virginia Safety and Health Codes Board

BRIEFING PACKAGE

For June 29, 2021

Occupational Exposure to COVID-19; Emergency Temporary Standard

I. Action Requested

The Virginia Occupational Safety and Health (VOSH) Program requests the Safety and Health Codes Board (SHCB) consider for adoption federal OSHA's Occupational Exposure to COVID-19; Emergency Temporary Standard ("COVID-19 ETS"), 1910.502, et seq., as published in 86 FR 32376 on June 21, 2021, as authorized by Virginia Code §§ 40.1-22(5) and 2.2-4006.A.4(c).

This briefing package provides an overview of the preamble to Federal OSHA's COVID-19 ETS. A link to the entire preamble can be found here:

<https://www.govinfo.gov/content/pkg/FR-2021-06-21/pdf/2021-12428.pdf>

The proposed effective date is August 2, 2021, and the COVID-19 ETS, and Virginia standard will remain in effect for the duration of the Federal emergency temporary standard, which may not exceed six (6) months.

For reasons explained further below, the Department recommends that the Board state in any motion it may make to adopt this standard that should the federal COVID-

19 Emergency Temporary Standard, 1910.502, et seq., applicable to settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board and take effect, application of Virginia's 16VAC-25-220, except for 16VAC-25-220-40 B.7.d and e, and 16VAC25-220-90, to such covered employers and employees subject to the standard shall be suspended while the federal COVID-19 Emergency Temporary Standard remains in effect.

The Department also recommends that the Board state in any motion it may make to adopt this standard that should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed or invalidated by a state or federal court, the provisions of Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required.

The Department further recommends that the Board state in any motion it may make to adopt this standard that should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to all settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed by federal OSHA, or otherwise revoked, repealed, declared unenforceable, or permitted to expire, the Virginia Safety and Health Codes Board shall within 30 days notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, or whether it should be revoked.

II. Summary of the Emergency Temporary Standard

Federal OSHA is issuing an emergency temporary standard (ETS) to protect healthcare and healthcare support service workers from occupational exposure to COVID-19 in settings where people with COVID-19 are reasonably expected to be present. During the period of the emergency standard, covered healthcare employers must develop and implement a COVID-19 plan to identify and control COVID-19 hazards in the workplace.

Covered employers must also implement other requirements to reduce transmission of COVID-19 in their workplaces, related to the following:

- patient screening and management;

- Standard and Transmission-Based Precautions;
- personal protective equipment (PPE), including facemasks or respirators;
- controls for aerosol-generating procedures;
- physical distancing of at least six feet, when feasible;
- physical barriers;
- cleaning and disinfection; ventilation;
- health screening and medical management;
- training;
- anti-retaliation;
- recordkeeping; and
- reporting.

The standard encourages vaccination by requiring employers to provide reasonable time and paid leave for employee vaccinations and any side effects. It also encourages use of respirators, where respirators are used in lieu of required facemasks, by including a “mini respiratory protection program” that applies to such use.

Finally, the standard exempts from coverage certain workplaces where all employees are fully vaccinated and individuals with possible COVID-19 are prohibited from entry; and it exempts from some of the requirements of the standard fully vaccinated employees in well-defined areas where there is no reasonable expectation that individuals with COVID-19 will be present.

III. History of COVID-19¹

The global pandemic of respiratory disease (coronavirus disease 2019 or “COVID-19”) caused by a novel coronavirus (SARS-CoV-2) has been taking an enormous toll on individuals, workplaces, and governments around the world since early 2020.

According to the World Health Organization (WHO), as of May 24, 2021, there had been 166,860,081 confirmed cases of COVID-19 globally, resulting in more than 3,459,996 deaths.² In the United States as of the same date, the CDC reported over 32,947,548 cases in the United States and over 587,342 deaths due to the disease.³

¹ For an in depth analysis of the history of COVID-19, see pgs. 9-13 of the preamble to the COVID-19 ETS.

² World Health Organization (WHO). (2021, May 24). WHO Coronavirus Disease (COVID-19) Dashboard. <https://covid19.who.int/table>. (WHO, May 24, 2021).

³ Centers for Disease Control and Prevention (CDC). (2021a, May 24). COVID data tracker. Trends in number of COVID-19 cases and deaths in the US reported to CDC, by state/territory: Trends in Total COVID-19 Deaths in the United States Reported to CDC. https://covid.cdc.gov/covid-data-tracker/#trends_dailytrendscases. (CDC, May 24, 2021a) and Centers for Disease Control and Prevention (CDC). (2021c, May 24). COVID data tracker. Trends in number of COVID-19 cases and deaths in the US reported to CDC, by state/territory: Trends in Total COVID-19 Cases in the United States Reported to CDC. https://covid.cdc.gov/covid-data-tracker/#trends_dailytrendscases. (CDC, May 24, 2021c).

Among healthcare workers specifically, as of May 24, 2021, 491,816 healthcare workers in the United States had contracted COVID-19, and at least 1,611 of those workers had died; both of those figures are likely an undercount.⁴

Despite the relatively rapid distribution of vaccines in many areas of the U.S., a substantial proportion of the working age population remains unvaccinated and susceptible to COVID-19 infection, including approximately a quarter of all healthcare and healthcare support workers.⁵

And, as discussed in more detail in the section entitled “Grave Danger” (Section V.A. of this briefing package), because workers in healthcare settings where COVID-19 patients are treated continue to have regular exposure to SARS-CoV-2 and any variants that develop, they remain at an elevated risk of contracting COVID-19 regardless of vaccination status.

Therefore, federal OSHA has determined that a grave danger to healthcare and healthcare support workers remains, despite the fully-vaccinated status of some workers, and that an ETS is necessary to address this danger (see “Grave Danger” and “Need for the ETS” (Sections V.A. and V.B. of this briefing package)).

IV. Legal Issues⁶

A. The OSH Act states that the Secretary “shall” issue an emergency temporary standard (ETS) if he finds that the ETS is necessary to address a grave danger to workers. See 29 U.S.C. 655(c). In particular, the statute reads:

The Secretary shall provide, without regard to the requirements of chapter 5, title 5, United States Code, for an emergency temporary standard to take immediate effect upon publication in the Federal Register if he determines –

(A) that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards, and

(B) that such emergency standard is necessary to protect employees from such danger. 29 U.S.C. 655(c)(1).

⁴ Centers for Disease Control and Prevention (CDC). (2021b, May 24). Cases & Deaths among Healthcare Personnel. <https://covid.cdc.gov/covid-data-tracker/#health-carepersonnel>. (CDC, May 24, 2021b)

⁵ King, WC, et al. (2021, April 24). COVID-19 vaccine hesitancy January-March 2021 among 18-64 year old US adults by employment and occupation. medRxiv; <https://www.medrxiv.org/content/10.1101/2021.04.20.21255821v3>. (King et al., April 24, 2021).

⁶ For an in depth analysis of legal pertinent authority, see pgs 13-19 of the preamble to the COVID-19 ETS.

The Secretary must issue an ETS in situations where employees are exposed to a “grave danger” and immediate action is necessary to protect those employees from such danger. 29 U.S.C. 655(c)(1); *Pub. Citizen Health Research Grp. v. Auchter*, 702 F.2d 1150, 1156 (D.C. Cir. 1983). The determination of what exact level of risk constitutes a “grave danger” is a “policy consideration that belongs, in the first instance, to the Agency.” *Asbestos Info. Ass’n/N. Am. v. OSHA*, 727 F.2d 415, 425 (5th Cir. 1984). (accepting OSHA’s determination that eighty lives at risk over six months was a grave danger); *Indus. Union Dep’t, AFL-CIO v. Am. Petroleum Inst.*, 448 U.S. 607, 655 n.62 (1980).

However, a “grave danger” represents a risk greater than the “significant risk” that federal OSHA must show in order to promulgate a permanent standard under section 6(b) of the OSH Act, 29 U.S.C. 655(b). *Int’l Union, United Auto., Aerospace, & Agr. Implement Workers of Am., UAW v. Donovan*, 590 F. Supp. 747, 755-56 (D.D.C. 1984), adopted, 756 F.2d 162 (D.C. Cir. 1985); see also *Indus. Union Dep’t, AFL-CIO*, 448 U.S. at 640 n.45 (noting the distinction between the standard for risk findings in permanent standards and ETSs).

Although Congress waived the ordinary rulemaking procedures in the interest of “permitting rapid action to meet emergencies,” section 6(e) of the OSH Act, 29 U.S.C. 655(e), requires federal OSHA to include a statement of reasons for its action when it issues any standard. *Dry Color Mfrs. Ass’n, Inc. v. Department of Labor*, 486 F.2d 98, 105-106 (3d Cir. 1973) (finding OSHA’s statement of reasons inadequate). By requiring the agency to articulate its reasons for issuing an ETS, the requirement acts as “an essential safeguard to emergency temporary standard-setting.” *Id. at 106*.

ETSs are, by design, temporary in nature. Under section 6(c)(3), an ETS serves as a proposal for a permanent standard in accordance with section 6(b) of the OSH Act (permanent standards), and the Act calls for the permanent standard to be finalized within six months after publication of the ETS. 29 U.S.C. 655(c)(3); see *Fla. Peach Growers Ass’n, Inc. v. U. S. Dep’t of Labor*, 489 F.2d 120, 124 (5th Cir. 1974).

The ETS is effective “until superseded by a standard promulgated in accordance with” section 6(c)(3). 29 U.S.C. 655(c)(2). It is crucial to note that the language of section 6(c)(1) is not discretionary: the Secretary “shall” provide for an ETS when OSHA makes the prerequisite findings of grave danger and necessity. *Pub. Citizen Health Research Grp. v. Auchter*, 702 F.2d 1150, 1156 (D.C. Cir. 1983) (noting the mandatory language of section 6(c)).

B. The Department of Labor and Industry’s Virginia Occupational Safety and Health (VOSH) program is charged with ensuring the protection of Virginia employees and employers from occupational safety and health hazards under Va. Code §40.1-1.

VOSH standards and regulations are adopted by the Virginia Safety and Health Codes Board (“Board”) in accordance with Va. Code §40.1-22(5) and -22(6a).

As a state plan for occupational safety and health under the OSH Act of 1970, Virginia is required to maintain occupational safety and health standards that are “at least as effective as” that of OSHA. 29 U.S.C. 667(c)(2).⁷

On January 21, 2021, President Biden issued an Executive Order⁸ on Protecting Worker Health and Safety which directed OSHA, among other things, to:

Sec. 2. Protecting Workers from COVID-19 Under the Occupational Safety and Health Act. The Secretary of Labor, acting through the Assistant Secretary of Labor for Occupational Safety and Health, in furtherance of the policy described in section 1 of this order and consistent with applicable law, shall:

....

(b) consider whether any emergency temporary standards on COVID-19, including with respect to masks in the workplace, are necessary, and if such standards are determined to be necessary, issue them by March 15, 2021:

OSHA submitted a proposed national Emergency Temporary Standard (OSHA’s ETS) for COVID-19 to the Office of Information and Regulatory Affairs (OIRA), Office of Management and Budget (OMB), on April 26, 2021.

On June 10, 2021, OSHA announced that it was issuing COVID-19 ETS and posted it, along with a preamble, on its website.⁹ The COVID-19 ETS becomes effective immediately upon publication in the Federal Register.

C. Code of Federal Regulations (CFR) Parts 1953(b)(1) and (b)(2) addresses state plan adoption of federal OSHA emergency temporary standards:

1953.5(b). Emergency temporary standards.

1953.5(b)(1). Immediately upon publication of an emergency temporary standard in the Federal Register, OSHA shall advise the States of the standard and that a Federal program change supplement shall be required. This notification must also provide that **the State has 30 days after the date of promulgation of the Federal standard to adopt a State emergency temporary standard if the State plan covers that issue. The State may demonstrate that**

⁷ <https://www.govinfo.gov/content/pkg/USCODE-2011-title29/html/USCODE-2011-title29-chap15-sec667.htm>

⁸ <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/21/executive-order-protecting-worker-health-and-safety/>

⁹ <https://www.osha.gov/coronavirus/ets>

promulgation of an emergency temporary standard is not necessary because the State standard is already the same as or at least as effective as the Federal standard change. The State standard must remain in effect for the duration of the Federal emergency temporary standard which may not exceed six (6) months.

1953.5(b)(2). Within 15 days after receipt of the notice of a Federal emergency temporary standard, the State shall advise OSHA of the action it will take. State standards shall be submitted in accordance with the applicable procedures in § 1953.4(b) -- Federal Program Changes, except that the required documentation or plan supplement must be submitted within 5 days of State promulgation. (Emphasis added).

C. The COVID-19 ETS is being adopted pursuant to Virginia Code §§ 40.1-22(5) and 2.2-4006.A.4(c):

§ 2.2-4006. Exemptions from requirements of this article.

A. The following agency actions otherwise subject to this chapter and § 2.2-4103 of the Virginia Register Act shall be exempted from the operation of this article:

....

4. Regulations that are:

....

c. Necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation, and the Registrar has so determined in writing. Notice of the proposed adoption of these regulations and the Registrar's determination shall be published in the Virginia Register not less than 30 days prior to the effective date of the regulation. (Emphasis added).

D. 16VAC25-220, Final Permanent Standard (FPS) for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50,¹⁰ currently applies to healthcare and healthcare support service workers and their employers where there is the potential for occupational exposure to the SARS-CoV-2 virus and COVID-19 disease.

The Department has conducted an “at least as effective as” (ALAEA) review and comparison of the COVID-19 ETS and the FPS and determined that in certain limited respects, the FPS does not provide protections to healthcare and healthcare support

¹⁰ <https://www.doli.virginia.gov/wp-content/uploads/2021/01/Final-Standard-for-Infectious-Disease-Prevention-of-the-Virus-That-Causes-COVID-19-16-VAC25-220-1.27.2021.pdf>

service workers in a manner that would be ALAFA the COVID-19 ETS. See “Side by Side Comparison of OSHA ETS to FPS,” DRAFT 6.21.2021, provided with this briefing package.

Therefore, the Department is recommending the adoption of the COVID-19 ETS in Virginia.

However, there is a long history of legal challenges in court to OSHA emergency temporary standards. “Six of the nine emergency standards that were issued [by OSHA] also were challenged. Of those six, only one was allowed to go into effect.”¹¹

Although the Department is proposing that the COVID-19 ETS be adopted as a federal identical standard as authorized by Virginia Code §§ 40.1-22(5) and 2.2-4006.A.4(c), the Department also agrees with federal OSHA’s findings that the SARS-CoV-2 virus (including its mutations/variations) and COVID-19 disease continue to present a grave danger to healthcare and healthcare support service workers (see discussion of “grave danger” below).

If OSHA’s COVID-19 ETS is challenged in court and becomes the subject of a federal court stay, or should OSHA issue an administrative stay, the legal basis for adopting the COVID-19 ETS as “necessary to meet the requirements of federal law or regulations” under Va. Code § 2.2-4006.A.4(c) would no longer be valid.

In addition, the COVID-19 ETS could be challenged in a Virginia court of law and be similarly stayed, or could lapse for any number of other reasons, any of which could result in healthcare and healthcare support service workers losing workplace safety and health protections provided not only by the COVID ETS, but also the FPS.

Accordingly, to avoid any potential lapse in workplace protections for healthcare and healthcare support service workers, the Department recommends that the Board state in any motion it may make to adopt this standard that should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board and take effect, application of Virginia’s 16VAC-25-220, except for 16VAC-25-220-40 B.7.d and e, and 16VAC25-220-90, to such covered employers and employees subject to the standard shall be suspended while the federal COVID-19 Emergency Temporary Standard remains in effect.

The Department also recommends that the Board state in any motion it may make to adopt this standard that should the federal COVID-19 Emergency Temporary Standard,

¹¹ <https://news.bloomberglaw.com/daily-labor-report/analysis-osh-emergency-covid-rule-imminent-but-vulnerable>

1910.502, et seq., applicable to settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed or invalidated by a state or federal court, the provisions of Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required.

The Department further recommends that the Board state in any motion it may make to adopt this standard that should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to all settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed by federal OSHA, or otherwise revoked, repealed, declared unenforceable, or permitted to expire, the Virginia Safety and Health Codes Board shall within 30 days notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, or whether it should be revoked.

V. Rationale for the COVID-19 ETS

A. Grave Danger

On January 31, 2020, the Secretary of Health and Human Services (HHS) declared COVID-19 to be a public health emergency in the U.S. under section 319 of the Public Health Service Act. The World Health Organization declared COVID-19 to be a global health emergency on the same day. President Donald Trump declared the COVID-19 outbreak to be a national emergency on March 13, 2020.¹²

HHS renewed its declaration of COVID-19 as a public health emergency effective April 21, 2021.¹³ Consistent with these declarations, and in carrying out its legal duties under the OSH Act, federal OSHA has determined that healthcare employees face a grave danger from the new hazard of workplace exposures to SARS-CoV-2 except under a limited number of situations.

¹² The White House. (2020, March 13). Proclamation on declaring a national emergency concerning the novel coronavirus disease (COVID-19) outbreak. <https://web.archive.org/web/20200313234554/https://www.whitehouse.gov/presidentialactions/proclamation-declaring-national-emergency-concerning-novel-coronavirusedisease-covid-19-outbreak/>. (The White House, March 13, 2020).

¹³ United States Department of Health and Human Services (US DHHS). (2021, April 15). Renewal of Determination That A Public Health Emergency Exists. <https://www.phe.gov/emergency/news/healthactions/phe/Pages/COVID15April2021.aspx>. (HHS, April 15, 2021).

The virus is both a physically harmful agent and a new hazard, and it can cause severe illness, persistent health effects, and death (morbidity and mortality, respectively) from the subsequent development of the disease, COVID-19. Federal OSHA bases its grave danger determination on evidence demonstrating the lethality of the disease, the serious physical and psychiatric health effects of COVID-19 morbidity (in mild-to-moderate as well as in severe cases), and the transmissibility of the disease in healthcare settings where people with COVID-19 are reasonably expected to be present.

The protections of the COVID-19 ETS—which will apply, with some exceptions, to healthcare settings where people may share space with COVID-19 patients or interact with others who do—are designed to protect employees from infection with SARS-CoV-2 and from the dire, sometimes fatal, consequences of such infection.

The fact that COVID-19 is not a uniquely work-related hazard does not change the determination that it is a grave danger to which employees are exposed, nor does it excuse employers from their duty to protect employees from the occupational transmission of SARS-CoV-2. The OSH Act is intended to “assure so far as possible every working man and woman in the Nation safe and healthful working conditions,” 29 U.S.C. 651(b), and there is nothing in the Act to suggest that its protections do not extend to hazards which might occur outside of the workplace as well as within.

Moreover, employees have more freedom to control their environment outside of work, and to make decisions about their behavior and their contact with others to better minimize their risk of exposure. However, during the workday, while under the control of their employer, healthcare employees providing care directly to known or suspected COVID-19 patients are required to have close contact with infected individuals, and other employees in those settings also work in an environment in which they have little control over their ability to limit contact with individuals who may be infected with COVID-19 even when not engaged in direct patient care.

Accordingly, even though SARS-CoV-2 is a hazard to which employees are exposed both inside and outside the workplace, healthcare employees in workplaces where individuals with suspected or confirmed COVID-19 receive care have limited ability to avoid exposure resulting from a work setting where those individuals are present. Federal OSHA has a mandate to protect employees from hazards they are exposed to at work, even if they may be exposed to similar hazards before and after work.

Federal OSHA’s previous ETSs addressed physically harmful agents that had been familiar to the agency for many years prior to the ETS. In most cases, the ETSs were issued in response to new information about substances that had been used in workplaces for decades (e.g., Vinyl Chloride (39 FR 12342 (April 5, 1974)); Benzene (42 FR 22516 (May 3, 1977)); 1,2-Dibromo-3-chloropropane (42 FR 45536 (Sept. 9, 1977))).

Unlike any of the hazards addressed in previous ETSs, SARS-CoV-2 was not known to exist in the United States until January, 2020. Since then, more than 3 million people have died worldwide and nearly 600,000 people have died in the U.S. alone.¹⁴

This monumental tragedy is largely handled by healthcare employees who provide care for those who are ill and dying, leading to introduction of the virus not only in their daily lives in the community but also in their workplace, and more than a thousand healthcare workers have died from COVID-19. Clearly, exposure to SARS-CoV-2 is a new hazard that presents a grave danger to workers in the U.S.

The section of the preamble of the COVID-19 ETS that deals with the discussion of what constitutes a “grave danger” includes a lengthy discussion on the nature of COVID-19 and its adverse effects to the general population. See “Nature of the Disease” on pages 30-79 of the preamble to the COVID-19 ETS. This Board already considered this information when adopting Virginia’s ETS and the Final Permanent Standard (“FPS”) so this briefing package does not include this information.

The following sections focus on vaccines which were not available at the time of the adoption of the Virginia ETS and FPS as well as the Impact of COVID-19 on Healthcare workers specifically.

1. The Effect on Vaccines on the Grave Danger Presented by SARS-CoV-2

The development of safe and highly effective vaccines and the on-going nationwide distribution of these vaccines are encouraging milestones in the nation’s response to COVID-19. Although there was initial uncertainty attached to the performance of authorized vaccines outside of clinical trials, vaccines have been in use for several months and they have proven effective in reducing transmission as well as the severity of COVID-19 cases.

Data now available clearly establish that fully-vaccinated persons (defined as two weeks after the second dose of the mRNA vaccines or two weeks after the

¹⁴ World Health Organization (WHO). (2021, May 24). WHO Coronavirus Disease (COVID-19) Dashboard. <https://covid19.who.int/table>. (WHO, May 24, 2021).

single dose vaccine) have a greatly reduced risk compared to unvaccinated individuals. This includes reductions in deaths, severe infections requiring hospitalization, and less severe symptomatic infections.

However, in healthcare settings where workers are vaccinated, as discussed below, the best available evidence establishes a grave danger *still* exists, given the greater potential for breakthrough cases in light of the greater frequency of exposure to suspected and confirmed COVID-19 patients in those settings.¹⁵

In addition, the best available evidence shows that vaccination has not eliminated the grave danger in mixed healthcare workplaces (i.e., those where some workers are fully vaccinated and some are unvaccinated) or in those healthcare workplaces where no one has yet been vaccinated.

The Effectiveness of Authorized Vaccines

There are currently three vaccines for the prevention of COVID-19 that have received EUAs from the FDA, allowing for their distribution in the U.S.: the PfizerBioNTech COVID-19 vaccine, the Moderna COVID-19 vaccine, and the Janssen COVID-19 vaccine.

Pfizer-BioNTech and Moderna are mRNA vaccines that require two doses administered three weeks and one month apart, respectively. Janssen is a viral vector vaccine that requires a single dose.¹⁶ The vaccines were shown to greatly exceed minimum efficacy standards in preventing COVID-19 in clinical trial participants.¹⁷

Data from clinical trials for all three vaccines and observational studies for the two mRNA vaccines clearly establish that fully vaccinated persons have a greatly reduced risk of SARS-CoV-2 infection compared to unvaccinated individuals. This includes severe infections requiring hospitalization and those resulting in death, as well as less severe symptomatic infections.¹⁸

¹⁵ Birhane, M et al. (2021, May 28) COVID-19 Vaccine Breakthrough Infections Reported to CDC — United States, January 1–April 30, 2021. *MMWR* 70: 792–793. <http://dx.doi.org/10.15585/mmwr.mm7021e3>. (Birhane et al., May 28, 2021).

¹⁶ Centers for Disease Control and Prevention (CDC). (2021, April 2). Science brief: background rationale and evidence for public health recommendations for fully vaccinated people. <https://www.cdc.gov/coronavirus/2019-ncov/science/sciencebriefs/fully-vaccinated-people.html>. (CDC, April 2, 2021).

¹⁷ Food and Drug Administration (FDA). (2021, February 26). Janssen COVID-19 vaccine. Vaccines and Related Biological Products Advisory Committee February 26, 2021 Meeting Briefing Document. <https://www.fda.gov/media/146219/download>. (FDA, February 26, 2021).

¹⁸ For more on the efficacy of the vaccines, see pages 81-87 of the preamble to the COVID-19 ETS.

On the other hand, healthcare workers treating suspected and confirmed COVID-19 patients are expected to have higher exposures to the SARS-CoV-2 virus than others in the workforce, because such work involves repeated instances of close contact with infected patients.¹⁹ Exposure can be even higher in aerosol generating activities. Indeed, one study reported higher infection rates among vaccinated healthcare workers during a regional COVID-19 surge.²⁰

Thus, the CDC has not relaxed infection control practices or PPE intended to protect healthcare workers, including respirator use.²¹ NIOSH has stated that the “available evidence shows that healthcare workers are continuing to become infected with SARS-CoV-2 . . . including both vaccinated and unvaccinated workers, and the conditions for the transmission of the virus exist at healthcare workplaces.”²²

Grave Danger Exists in Healthcare Workplaces Where Unvaccinated Workers Are Present.

The evidence shows that the advent of vaccines does not eliminate the grave danger from exposure to SARS-CoV-2 in healthcare workplaces where less than 100% of the workforce is fully vaccinated. Unvaccinated workers can transmit the virus to each other and can become infected as a result of exposure to persons with COVID-19 who enter the healthcare facility.

An outbreak of COVID-19 due to an unvaccinated, symptomatic healthcare workers was recently reported in a skilled nursing facility in which 90.4% of residents had been vaccinated.²³ The outbreak, due to the R.1 variant, caused attack rates that were three to four times higher in unvaccinated residents and healthcare workers as among those who were vaccinated. Additionally,

¹⁹ Howard, J. (2021, May 22). “Response to request for an assessment by the National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, of the current hazards facing healthcare workers from Coronavirus Disease-2019 (COVID-19).” (Howard, May 22, 2021).

²⁰ Keehner et al. (2021, May 6). SARS-CoV-2 infection after vaccination in health care workers in California. *New England Journal of Medicine* 384(18). (Keehner et al., May 6, 2021).

²¹ Centers for Disease Control and Prevention (CDC). (2021a, April 27). Updated healthcare infection prevention and control recommendation in response to COVID-19 vaccination. [https://www.cdc.gov/coronavirus/2019-ncov/healthcare workers/infection-control-aftervaccination.html](https://www.cdc.gov/coronavirus/2019-ncov/healthcare%20workers/infection-control-aftervaccination.html). (CDC, April 27, 2021a).

²² Howard, J. (2021, May 22). “Response to request for an assessment by the National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, of the current hazards facing healthcare workers from Coronavirus Disease-2019 (COVID-19).” (Howard, May 22, 2021).

²³ Cavanaugh, AM et al. (2021, April 30). COVID-19 outbreak associated with a SARSCoV-2 R.1 lineage variant in a skilled nursing facility after vaccination program — Kentucky, March 2021. *MMWR* 70: 639-643. <http://dx.doi.org/10.15585/mmwr.mm7017e2>. (Cavanaugh et al., April 30, 2021).

unvaccinated persons were significantly more likely to experience symptoms or require hospitalization. Therefore, unvaccinated employees at these workplaces remain at grave danger of infection, along with the serious health consequences of COVID-19.

Even in the healthcare industry, where distribution has enabled entire worker populations to be completely vaccinated by now, some workers exhibited reluctance to getting vaccinated. On January 4, 2021, a study of 1,398 U.S. emergency department health care personnel found that 95% were offered the vaccine, with 14% declining.²⁴

In February of 2021, the CDC released a study of initial vaccine efforts at skilled nursing facilities offering long-term care.²⁵ The study found that only 37.5% of eligible staff were vaccinated, leaving a potentially significant population vulnerable to SARS-CoV-2 infections and capable of transmission.

That unvaccinated healthcare workers remain in grave danger is emphasized by the fact that thousands of new hospital admissions still occur each day in the midst of significant distribution of over three hundred million effective vaccine doses.²⁶ These factors indicate that transmission remains robust and significant portions of the population remain vulnerable to COVID-19.

Spread of the disease within the healthcare workforce may start with a worker becoming ill through community transmission or an ill patient seeking treatment. The rate of new cases, hospitalizations, and deaths peaked in January 2021, just before vaccines became more widely available outside of healthcare settings.

The January to February decline, however, is likely not attributable in large part to the new vaccines alone, because only a small portion of the population had received them. During this time, variants of concern, such as B.1.1.7, that are more transmissible and may result in worse health outcomes, have become the

²⁴Schrading, WA et al. (2021, February 19). Vaccination rates and acceptance of SARS-CoV-2 vaccination among U.S. emergency department health care personnel. *Acad Emerg Med* 28: 455-458. (Schrading et al., February 19, 2021).

²⁵ Gharpure, R et al. (2021, February 5) Early COVID-19 first-dose vaccination coverage among residents and staff members of skilled nursing facilities participating in the pharmacy partnership for long-term care program — United States, December 2020– January 2021. *MMWR* 2021; 70: 178–182. DOI: <http://dx.doi.org/10.15585/mmwr.mm7005e2>. (Gharpure et al., February 5, 2021).

²⁶ Centers for Disease Control and Prevention (CDC). (2021b, May 24). COVID data tracker. New Admissions of Patients with Confirmed COVID-19, United States. <https://covid.cdc.gov/covid-data-tracker/#new-hospital-admissions>. (CDC, May 24, 2021b).

majority source of infection.²⁷ Hundreds of people each day are still dying of COVID-19 in early May 2021, many of them working-age adults.²⁸

2. Impact on Healthcare Employees

Data on SARS-CoV-2 infections, illnesses, and deaths among healthcare employees supports federal OSHA's finding that COVID-19 poses a grave danger to these employees. Even fairly brief exposure (i.e. 15 minutes during a 24-hour period) can lead to infection, which in turn can cause death or serious impairment of health.

Employees in healthcare settings include healthcare employees, who provide direct patient care (e.g., nurses, doctors, and emergency medical technicians (EMTs)), and healthcare support employees, who provide services that support the healthcare industry and may have contact with patients (e.g., laundry, janitorial/housekeeping, and food service employees). Employees who perform autopsies are also considered to work in healthcare. Most employees who work in healthcare perform duties that put them at elevated risk of exposure to SARS-CoV-2.

Healthcare employees who provide direct patient care are at high risk of exposure to SARS-CoV-2 because they have close and sometimes prolonged contact with patients who are infected or potentially infected with SARS-CoV-2.

This contact occurs when conducting physical examinations and providing treatment and medical support. The risk can be amplified when examining or treating a COVID-19 patient who has symptoms such as coughing and difficulty breathing (leading to more forceful inhalation and exhalation), both of which can result in the release of more droplets that can be propelled further.

Healthcare employees who conduct, or provide support during, aerosol-generating procedures on persons with suspected or confirmed COVID-19 also face a greater risk of infection.²⁹ Examples of procedures that can produce aerosols include intubation, suctioning airways, use of high-speed tools during dental work, and use of power saws during autopsies. A complete list of

²⁷ Centers for Disease Control and Prevention (CDC). (2021c, May 24). Variant Proportions. <https://covid.cdc.gov/covid-data-tracker/#variant-proportions>. (CDC, May 24, 2021c).

²⁸ Centers for Disease Control and Prevention (CDC). (2021d, May 24). COVID-19 Weekly Deaths per 100,000 Population by Age by Age, Race/Ethnicity, and Sex. <https://covid.cdc.gov/covid-data-tracker/#demographicsovertime>. (CDC, May 24, 2021d).

²⁹ Heinzerling, A et al. (2020, April 17). Transmission of COVID-19 to Health Care Personnel During Exposures to a Hospitalized Patient — Solano County, California, February 2020. *MMWR Morb Mortal Wkly Rep* 2020; 69: 472–476. DOI: <http://dx.doi.org/10.15585/mmwr.mm6915e5>. (Heinzerling et al., April 17, 2020).

aerosol-generating procedures, as defined by the COVID-19 ETS, is included in 29 CFR 1910.502(b).

Employees in healthcare are also at risk of exposure to SARS-CoV-2 if they have close contact with co-workers while providing patient care or performing other duties in enclosed areas such as a nursing station, laundry room, or kitchen.

Conclusion

Federal OSHA finds that healthcare employees face a grave danger from exposure to SARS-CoV-2 in the United States. The best available evidence on the science of transmission of the virus makes clear that SARS-CoV-2 is transmissible from person to person in these healthcare settings, which can result in largescale clusters of infections.

Transmission is most prevalent in healthcare settings where individuals with suspected or confirmed COVID-19 receive care, and can be exacerbated by, for example, poor ventilation, close contact with potentially infectious individuals, and situations where aerosols containing SARS-CoV-2 particles are likely to be generated.

Every healthcare workplace exposure or transmission has the potential to cause severe illness or even death, particularly in unvaccinated healthcare workers in settings where patients with suspected or confirmed COVID-19 receive care. Taken together, the multiple, severe health consequences of COVID-19 and the evidence of its transmission in environments characteristic of the healthcare workplaces where the COVID-19 ETS requires worker protections demonstrate that exposure to SARS-CoV-2 represents a grave danger to employees in these workplaces throughout the country.

The existence of a grave danger to employees from SARS-CoV-2 is further supported by the toll the pandemic has already taken on the nation as a whole. Although federal OSHA cannot estimate the total number of healthcare workers in our nation who contracted COVID-19 at work and became sick or died, COVID-19 has killed 587,342 people in the United States as of May 24, 2021.³⁰

³⁰ Centers for Disease Control and Prevention (CDC). (2021a, May 24). COVID data tracker. Trends in number of COVID-19 cases and deaths in the US reported to CDC, by state/territory: Trends in Total COVID-19 Deaths in the United States Reported to CDC. https://covid.cdc.gov/covid-datatracker/#trends_dailytrendscases. (CDC, May 24, 2021a).

That death toll includes 91,351 people who were 18 to 64 years old.³¹ Current mortality data shows that unvaccinated people of working age have a 1 in 217 chance of dying when they contract COVID-19. As of May 24, 2021, more than 32 million people in the United States have been reported to have infections, and thousands of new cases were being identified daily.³² One in ten reported cases of COVID-19 becomes severe and requires hospitalization.

This analysis satisfies the OSH Act's requirements for finding a grave danger. Having made the determination of grave danger, as well as the determination that an ETS is necessary to protect these employees from exposure to SARS-CoV-2 (discussed in the next section of this briefing package), Federal OSHA is required to issue this standard to protect these employees from getting sick and dying from COVID-19 acquired at work. See 29 U.S.C. 655(c)(1).

B. Need for the COVID-19 ETS

The COVID-19 ETS is necessary to protect the healthcare workers with the highest risk of contracting COVID-19 at work. Healthcare workers face a particularly elevated risk of contracting COVID-19 in settings where patients with suspected or confirmed COVID-19 receive treatment, especially those healthcare workers providing direct care to patients.

The COVID-19 ETS is necessary to protect these workers through requirements including patient screening and management, respirators and other personal protective equipment (PPE), limiting exposure to aerosol-generating procedures, physical distancing, physical barriers, cleaning, disinfection, ventilation, health screening and medical management, access to vaccination, and anti-retaliation provisions and medical removal protection.

Below is a discussion of why the existing OSHA framework, guidance, and status of the vaccination program in the United States is currently inadequate to protect healthcare workers at high risk of contracting COVID-19, thus necessitating the adoption of the COVID-19 ETS.

The Current Standards and Regulations are Inadequate

³¹ Centers for Disease Control and Prevention (CDC). (2021b, May 24). Demographic Trends of COVID-19 cases and deaths in the US reported to CDC: Deaths by age group. <https://covid.cdc.gov/covid-data-tracker/#demographics>. (CDC, May 24, 2021b).

³² Centers for Disease Control and Prevention (CDC). (2021c, May 24). COVID data tracker. Trends in number of COVID-19 cases and deaths in the US reported to CDC, by state/territory: Trends in Total COVID-19 Cases in the United States Reported to CDC. https://covid.cdc.gov/covid-data-tracker/#trends_dailytrendscases. (CDC, May 24, 2021c).

In updated enforcement guidance issued in March 2021, federal OSHA identified a number of current standards and regulations that might apply when workers have occupational exposure to SARS-CoV-2 (Interim Enforcement Response Plan).³³ In addition to the standards listed there, federal OSHA has also cited the Hazard communication standard (29 CFR part 1910.1200) during COVID-19 investigations. Accordingly, the complete list of potentially applicable standards and regulations follows:

- 29 CFR Part 1904, Recording and Reporting Occupational Injuries and Illnesses. This regulation requires certain employers to keep records of work related fatalities, injuries, and illnesses and report them to the government in specific circumstances.
- 29 CFR part 1910.132, General requirements — Personal Protective Equipment (PPE). This standard requires that appropriate PPE, including PPE for eyes, face, head, and extremities, protective clothing, respiratory devices, and protective shields and barriers, be provided, used, and maintained in a sanitary and reliable condition.
- 29 CFR part 1910.134, Respiratory protection. This standard requires that employers provide, and ensure the use of, appropriate respiratory protection when necessary to protect employee health.
- 29 CFR part 1910.141, Sanitation. This standard applies to permanent places of employment and contains, among other requirements, general housekeeping and waste disposal requirements.
- 29 CFR part 1910.145, Specification for accident prevention signs and tags. This standard requires the use of biological hazard signs and tags, in addition to other types of accident prevention signs and tags.
- 29 CFR part 1910.1020, Access to employee exposure and medical records. This standard requires that employers provide employees and their designated representatives access to relevant exposure and medical records.
- 29 CFR part 1910.1200, Hazard communication. This standard requires employers to keep Safety Data Sheets (SDS) for chemical hazards, provide SDSs to employees and their representatives when requested, and train employees

³³ Occupational Safety and Health Administration (OSHA). (2021, March 12). Enforcement Memo: Updated Interim Enforcement Response Plan for Coronavirus Disease 2019 (COVID-19). <https://www.osha.gov/memos/2021-03-12/updated-interim-enforcementresponse-plan-coronavirus-disease-2019-covid-19>. (OSHA, March 12, 2021).

about those hazards. The standard does not apply to biological hazards, but hazard communication becomes an issue for the SARS-CoV-2 virus when chemicals are used to disinfect surfaces. OSHA notes that, when such chemicals are used in the workplace, the employer is required to comply with the hazard communication standard. The agency has not incorporated hazard communication requirements in the COVID-19 ETS, but has included related training and notification requirements. Section 1910.1200 compliance is only peripherally related to protection against SARSCoV-2 hazards, employers are generally aware of those requirements, and the requirements of § 1910.1200 are enforceable without being repeated in the COVID-19 ETS.

Through its enforcement efforts to date, federal OSHA has encountered significant obstacles, demonstrating that existing standards and regulations are inadequate to address the COVID-19 hazard for healthcare workers, and has determined that a COVID-19 ETS is necessary to address these inadequacies. Current CDC guidance does not indicate that respirators are generally needed outside of direct patient care, but CDC does support the protective measures the COVID-19 ETS would require for the workers it covers.³⁴

Finally, the remaining listed standards and regulations—for recordkeeping and reporting, accident prevention signs and tags, access to employee records, and hazard communication—while applicable to the COVID-19 hazard and important in the overall scheme of workplace safety, do not require employers to implement specific measures to protect workers from COVID-19.³⁵

The General Duty Clause

Section 5(a)(1) of the OSH Act, or the General Duty Clause, provides the general mandate that each employer “furnish to each of [its] employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.” 29 U.S.C. 654(a)(1).

While federal OSHA has attempted to use the General Duty Clause to protect employees from COVID-19 related hazards, federal OSHA has found that there are significant challenges associated with this approach and therefore the COVID-19

³⁴ Howard, J. (2021, May 22). “Response to request for an assessment by the National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, of the current hazards facing healthcare workers from Coronavirus Disease-2019 (COVID-19).” (Howard, May 22, 2021).

³⁵ For an extensive explanation as to why federal OSHA found these existing standards were inadequate 161-166 of the preamble to the federal COVID-19 ETS.

ETS is necessary to protect the workers covered by this standard from the grave danger posed by COVID-19.

While the General Duty Clause can be used in many contexts, in federal OSHA's experience over the past year, the clause fell short of the agency's mandate to protect employees from the hazards of COVID-19 in the settings covered by the standard. As explained more fully below, federal OSHA finds the COVID-19 ETS will more efficiently and effectively address those hazards.

Several characteristics of General Duty Clause enforcement actions limit how effectively federal OSHA can use the clause to address hazards associated with COVID-19. Most important, the General Duty Clause is not a good tool for requiring employers to adopt specific, overlapping, and complementary abatement measures, like those required by the COVID-19 ETS, and some important worker-protective elements of the COVID-19 ETS (such as payment for medical removal) would be virtually impossible for federal OSHA to require and enforce under the General Duty Clause.

The COVID-19 ETS will enable federal OSHA to issue more meaningful penalties for willful or egregious violations, thus facilitating better enforcement and more effective deterrence against employers who intentionally disregard their obligations under the Act or demonstrate plain indifference to employee safety.

Lastly, the General Duty Clause does not provide complete protection to employees at multi-employer worksites, which are common situations in hospitals, where more than one employer controls hazards at the workplace. The COVID-19 ETS will permit more thorough enforcement in these situations.³⁶

Federal OSHA and Other Entity Guidance is Insufficient

Federal OSHA has issued numerous non-mandatory guidance products to advise employers on how to protect workers from SARS-CoV-2 infection. (See <https://www.osha.gov/coronavirus>). Even the most comprehensive guidance makes clear, as it must, that the guidance itself imposes no new legal obligations, and that its recommendations are "advisory in nature." (See OSHA's online guidance, *Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace* (January 29, 2021); and OSHA's earlier 35-page booklet, *Guidance on Preparing Workplaces for Covid-19* (March 9, 2020)).

³⁶ For more information on how Federal OSHA found the General Duty in practice to be insufficient to protect workers, see pages 166-179 of the preamble to the COVID-19 ETS.

This guidance, as well as guidance materials issued by other government agencies and organizations, including the CDC, the Centers for Medicare & Medicaid Services (CMS), the Institute of Medicine (IOM), and the World Health Organization (WHO), help protect employees to the extent that employers voluntarily choose to implement the practices they recommend. Unfortunately, federal OSHA's experience shows that does not happen consistently or rigorously enough, resulting in inadequate protection for employees.³⁷

Recent Vaccine Developments Demonstrate the Importance of the COVID-19 ETS; They do not Obviate the Current Need for the COVID-19 ETS

The development and availability of safe and highly effective vaccines is an important development in the nation's response to COVID-19. The very low percentage of breakthrough cases (illness among vaccinated people) have led to recent updates to CDC guidance acknowledging vaccination as an effective control to prevent hospitalization and death from COVID-19 to such an extent that the CDC has concluded that most other controls are not necessary to protect vaccinated people outside healthcare settings.

In the United States, all people ages 12 and older are eligible to be vaccinated, and vaccines are readily available in most parts of the country. However, despite the success of this vaccine program and the substantial promise that vaccines hold, federal OSHA does not believe they eliminate the need for this standard.

Federal OSHA embraces the value of vaccination and views the COVID-19 ETS as essential to facilitating access to this critical control for those workers who wish to receive it while still protecting those who cannot be, or will not be, vaccinated.³⁸

However, for vaccines to be effective, workers need first to actually receive them. While the supply of vaccines and their distribution continues to increase, as of the date of the promulgation of this standard, approximately a quarter of healthcare workers have not yet completed COVID-19 vaccination with many of those expressing vaccine hesitation.³⁹

³⁷For more discussion on how the current guidance has proved inadequate to protect healthcare workers, see pages 179-183 of the preamble to the COVID-19 ETS.

³⁸ By excluding certain workplaces and well-defined work areas where all employees are fully vaccinated from all requirements of the standard (paragraphs (a)(2)(iv) and (v)), and exempting fully vaccinated workers in certain settings where not all employees are vaccinated from several requirements of the standard (paragraph (a)(4)), the COVID-19 ETS encourages vaccination for employers and employees who do not want to follow those requirements.

³⁹ King, WC et al. (2021, April 24). COVID-19 vaccine hesitancy January-March 2021 among 18-64 year old US adults by employment and occupation. medRxiv; <https://www.medrxiv.org/content/10.1101/2021.04.20.21255821v3>. (King et al., April 24, 2021).

Although a majority of Americans over 65 are vaccinated, the percentage among the working-age population is much lower (44%).⁴⁰ There are several barriers to vaccination for the working-age population. Many employees who want to be vaccinated may be unable to do so unless the employer authorizes time off work, or may be financially unable to absorb a reduced paycheck for taking unpaid leave to be vaccinated or potentially missing a significantly larger period of time from work (and a larger financial hit) because of the potential side effects of the vaccination.⁴¹

Further, there is a need to continue building vaccine confidence in some parts of the population, making the COVID-19 ETS even more important to assure safe working conditions during the period before these workers are vaccinated. As discussed in more depth in “Grave Danger” (Section V.A. of this briefing package), even though vaccines are now more readily available, they do not protect all workers.

Some workers are unable to be vaccinated for medical or other reasons, even if they are willing to be. And in immunocompromised workers, vaccines can be considerably less effective than in immunocompetent individuals.

And while some employees may simply elect not to be vaccinated for personal reasons, federal OSHA has a statutory duty to ensure that employers protect those employees from the grave danger of COVID-19 regardless of their basis for refusing vaccination. These factors, along with the uneven vaccination rates among some subpopulations, such as the Latinx and Black populations, who have been disproportionately harmed by the virus but also have the lowest vaccination rates, make the need for this COVID-19 ETS especially acute.⁴²

This COVID-19 ETS can help facilitate vaccination among those groups, protect those who cannot or will not be vaccinated, and thereby mitigate the disproportionate impacts of the virus for workers in these groups. Even when the COVID-19 ETS helps currently unvaccinated workers overcome the obstacles to becoming vaccinated, they must still be protected by the other measures of this

⁴⁰Centers for Disease Control and Prevention (CDC). (2021a, May 24). Demographic Trends of People Receiving COVID-19 Vaccinations in the United States. <https://covid.cdc.gov/covid-data-tracker/#vaccination-demographics-trends>. (CDC, May 24, 2021a).

⁴¹ SEIU Healthcare. (2021, February 8). Research shows 81% of healthcare workers willing to take COVID-19 vaccines but personal financial pressures remain a significant barrier for uptake. <https://www.newswire.ca/news-releases/research-shows-81-of-healthcareworkers-willing-to-take-covid-19-vaccines-but-personal-financial-pressures-remain-asignificant-barrier-for-uptake-888810789.html>. (SEIU Healthcare, February 8, 2021).

⁴² Ndugga, N et al. (2021, February 18). Latest Data on COVID-19 Vaccinations Race/Ethnicity. Kaiser Family Foundation. <https://www.kff.org/coronavirus-covid19/issue-brief/latest-data-on-covid-19-vaccinations-race-ethnicity/>. (Ndugga et al., February 18, 2021).

standard until they are fully protected by the vaccine. With the two-dose vaccines in particular, the time from a first shot to fully effective vaccination is 5 to 6 weeks.

Furthermore, also increasing are new virus variants, the most prevalent of which, the B.1.1.7 variant first identified in the U.K., now appears responsible for almost 66% of the cases in the U.S.⁴³ While the currently authorized vaccines appear effective against all of the variants now circulating, promoting vaccination as quickly as possible becomes even more critical because the variant is not only more transmissible, it also appears to cause more severe disease.

CNN.com, June 15, 2021, "CDC now calls coronavirus **Delta variant** a 'variant of concern'"⁴⁴

"The US Centers for Disease Control and Prevention now calls the Delta variant of the novel coronavirus, also known as B.1.617.2, a "variant of concern."

The variant of concern designation is given to strains of the virus that scientists believe are more transmissible or can cause more severe disease. Vaccines, treatments and tests that detect the virus may also be less effective against a variant of concern. Previously, the CDC had considered the Delta variant to be a variant of interest.

The CDC said the Delta variant, which was first identified in India, shows increased transmissibility, potential reduction in neutralization by some monoclonal antibody treatments under emergency authorization and potential reduction in neutralization from sera after vaccination in lab tests.

....

Covid-19 cases have been declining over the past few months in the United States, but there's concern that could change as the pace of vaccinations slows and the Delta variant spreads. The CDC estimates it accounted for 9.9% of cases in the US as of June 5.

[As of June 22, 2021, the Delta variant now makes up about 20% of cases in the U.S.⁴⁵]

⁴³ Centers for Disease Control and Prevention (CDC). (2021b, May 24). Variant Proportions. <https://covid.cdc.gov/covid-data-tracker/#variant-proportions>. (CDC, May 24, 2021b).

⁴⁴ <https://www.cnn.com/2021/06/15/health/delta-variant-of-concern-cdc-coronavirus/index.html>

⁴⁵ <https://www.cnn.com/2021/06/22/fauci-declares-delta-variant-greatest-threat-to-the-nations-efforts-to-eliminate-covid.html>

At a White House Covid-19 briefing last week, National Institute of Allergy and Infectious Diseases Director Dr. Anthony Fauci encouraged everyone to get vaccinated against Covid-19, noting that the Delta variant is was in circulation in the United States at a rate similar to the tipping point seen in the UK, where the variant is now dominant.

....

The variant is believed to be responsible for the most recent rise in cases in the UK and a study of cases in Scotland published on Monday found that it was associated with about double the risk of hospitalization compared with the Alpha variant, B.1.1.7, that was first identified in the UK.

The UK announced Monday that the easing of coronavirus restrictions would be delayed another four weeks, until July 19, following a rise in cases and, in particular, the growing spread of the Delta variant."

....

As of Sunday, the Delta variant was responsible for about 10.3% of US Covid-19 cases, according to Dr. Eric Topol, the founder and director of the Scripps Research Translational Institute, whose outbreak.info has been tracking variants throughout the pandemic.

The may not seem like a lot, but the speed with which it's spreading is a concern. "It doubles every seven to 10 days, which means when it gets to three weeks from now, this variant will be dominant," Topol said. "That means we have two to three weeks to just go flat out with vaccination to stop this trend."

[As of June 22, 2021, the Delta variant now makes up about 20% of cases in the U.S.⁴⁶]

....

"This is the most troubling variant by far, because it's another 60% more contagious than the Alpha, so it's a super spreader strain," Topol said. But the vaccination rate is stalling.

While 43.9% in the US is fully vaccinated, according to the CDC, the rate at which people are getting vaccinated has been slowing down. In Mississippi, nearly 29% of population is fully vaccinated. In Alabama it's less than 31%. In Arkansas, less than 33%. In Louisiana, Georgia, and Wyoming it's less than 34%, according to CDC data.

....

⁴⁶ <https://www.cnn.com/2021/06/22/fauci-declares-delta-variant-greatest-threat-to-the-nations-efforts-to-eliminate-covid.html>

The good news is that people who are fully vaccinated seem to have solid protection against the Delta variant. A study published in the Lancet found a single dose of Covid-19 vaccine wasn't enough, but after the second dose, the Pfizer-BioNTech provided 79% protection from the Delta variant. That compares with 92% protection against the Alpha variant. Another analysis from England's public health agency found two doses of the Pfizer vaccine seemed 96% effective against hospitalization.”

Finally, while the science continues to develop, the full extent and duration of the immune response remains unknown. Additional evidence is also needed to determine the extent to which people who are vaccinated could still be infected and transmit the disease to others, even if they themselves are protected from the worst health effects. Although such cases do not appear to be common, the COVID-19 ETS would help protect these employees and their co-workers in mixed groups of vaccinated and unvaccinated people.

These issues, as already discussed in the section on grave danger (Section V.A. of this briefing package) demonstrate that the various protections required in the COVID-19 ETS are still necessary, even for workplaces in which many but not all members of the workforce have been vaccinated.

Due to the inadequacies of current standards, the general duty clause, federal OSHA guidance and other entity guidance, as well as the need for more vaccination to occur as described above, federal OSHA finds the COVID-19 ETS necessary to protect healthcare workers with the highest risk of contracting COVID-19 at work.

VI. Brief Overview of Provisions of the COVID-19 ETS

The full text of the COVID-19 ETS is attached to this briefing package. For an in depth discussion on how Federal OSHA determined what was required to be in the COVID-19 ETS, see pages 631-972 of the preamble to the COVID-19 ETS.⁴⁷ This section provides a brief overview of each section in the COVID-19 ETS:

§1910.502 Healthcare

- §1910.502(a) *Scope and Application*— COVID-19 ETS applies to all settings where any employee provides healthcare services or healthcare support services. This section exempts several employers that would be considered a healthcare setting but for Federal OSHA excluding them from the COVID-19 ETS. Exemptions include:

⁴⁷ <https://www.osha.gov/sites/default/files/covid-19-healthcare-ets-preamble.pdf>

- Dispensing of prescriptions by pharmacists in retail setting
- Non-hospital ambulatory care where non-employees are screened prior to entry
- Ambulatory care settings where employees are fully vaccinated and all non-employees are screened prior to entry
- Home healthcare settings where all employees are fully vaccinated and all non-employees are screened prior to entry
- Healthcare support services not performed in a healthcare setting (e.g. offsite laundry, billing, etc.)
- Telehealth services performed outside of a setting where direct patient care occurs
- §1910.502(b) *Definitions*—contains a list of definitions that apply to the COVID-19 ETS
- §1910.502(c) *COVID-19 plan*—Each employer must create and implement a COVID-19 plan for each workplace. Requirements of the plan include:
 - Must be in writing if employer has more than 10 employees
 - Workplace must designate at least one “COVID-19 safety coordinator” to implement and monitor COVID-19 plan
 - Employer must conduct hazard assessment of workplace
 - To qualify for exemption in (a)(4) based on employees’ fully vaccinated status, plan must include policies to determine employees’ vaccination status
 - Employer must seek employee input in coming up with plan
 - Employer must monitor workplace to ensure effectiveness of plan
 - Plan must address hazards identified by assessment required and include policies to minimize risk of transmission of COVID-19. Plan must also include policies for employers sharing its COVID-19 plan with other employers who share the same physical location
 - Plan must also include policies for protecting employees when in course of their employment enter into private residences
- §1910.502(d) *Patient Screening and Management*—Where direct patient care is provided employer must limit and monitor points of entry, screen and triage all clients, patients residents and other visitors entering the setting.
- §1910.502(e) *Standard and Transmission-Based Precautions*-- Employers must develop and implement policies and procedures to adhere to Standard and Transmission-Based Precautions in accordance with CDC’s “Guidelines for Isolation Precautions” (incorporated by reference, § 1910.509).
- §1910.502(f) *Personal Protective Equipment*—Covers requirements for facemasks, faceshields, respirators, gloves, isolation gowns and limited exceptions to the

facemask requirement (employee alone in a room, while employee is eating and drinking while physical distancing, when required to wear other respiratory protection under § 1910.134, ADA disability, religious beliefs) Also covers when an employee is required to be provided and wear a respirator after a confirmed exposure to a confirmed or suspected case of COVID-19.

- §1910.502(g) *Aerosol-generating procedures*—contains requirements for employees performing aerosol-generating procedures on patients with suspected or confirmed COVID-19.
- §1910.502(h) *Physical distancing*—contains situation in which employees must physically distance from one another.
- §1910.502(i) *Physical barriers*—includes requirement to install cleanable or disposable solid barriers at each fixed work location where employee is not separated from all other people by at least 6 feet.
- §1910.502(j) *Cleaning and Disinfection*—Employers must follow standard practices for cleaning and disinfection of surfaces and equipment in accordance with CDC’s “COVID-19 Infection Prevention and Control Recommendation” and CDC’s “Guidelines for Environmental Infection Control” at pages 86-103, 147-149.
- §1910.502(k) *Ventilation*—Contains requirements for HVAC system(s) within structures in which the employer has control or owns. This section also contains requirements for AIIRs. This section does not require installation of new HVAC system and AIIRs.
- §1910.502(l) *Health screening and medical management*—this section contains screening requirements for all employees before each work day and shift. Provisions include:
 - Requirement for employer to provide COVID-19 test to employee if required for screening purposes
 - Requirement that employees notify employer of any COVID-19 positive test, suspected COVID-19 diagnosis by healthcare provider, loss of taste and/or smell, fever and shortness of breath
 - Requirement to notify each employee who was not wearing a respirator and any other required PPE and has been in close contact with a person with a confirmed case of COVID-19 in the workplace. The notification must contain the date the contact occurred.
 - Requirement to notify other employees who were not wearing a respirator and any other required PPE and worked in a well-defined portion of a workplace (e.g., a particular floor) during the same time in which a person with a

- confirmed case of COVID-19 was present during the potential transmission period
 - Requirement to notify employers whose employees were not wearing respirators and any other required PPE and have been in close contact with that person, or worked in a well-defined portion of a workplace in which that person was present, during the potential transmission period.
 - Notifications required by this section cannot contain person's name, contact information or occupation
 - The section also discusses when medical removal of an employee from the workplace is required
- §1910.502(m) *Vaccination*—Employer must support COVID-19 vaccination for each employee by providing reasonable time and paid leave (e.g., paid sick leave, administrative leave) to each employee for vaccination and any side effects experienced following vaccination.
- §1910.502(n) *Training*—section includes training employee must receive including training on how COVID-19 is transmitted, procedures for wearing PPE, policies on cleaning and disinfection, policies on screening and health management, available sick leave policies, any COVID-19-related benefits to which the employee may be entitled under applicable federal, state, or local laws, and identity of safety coordinator.
- §1910.502(o) *Anti-retaliation*—employer must inform employee that employer cannot discriminate or discharge employee for exercising right to protections required by standard
- §1910.502(p) *Requirements implemented at no cost to employees*—implementation of standard must come at no cost to employee
- §1910.502(q) *Recordkeeping*—Applies to employers with 10 or more employees. Employers must keep all versions of the COVID-19 plan, establish and maintain COVID-19 log to record each instance identified by the employer in which an employee is COVID-19 positive, regardless of whether the instance is connected to exposure to COVID-19 at work. The COVID-19 log must contain, for each instance, the employee's name, one form of contact information, occupation, location where the employee worked, the date of the employee's last day at the workplace, the date of the positive test for, or diagnosis of, COVID-19, and the date the employee first had one or more COVID-19 symptoms, if any were experienced and must be recorded within 24 hours of employer learning of employee is COVID-19 positive.

- §1910.502(r) *Reporting COVID-19 fatalities and hospitalizations to OSHA*—must report within 8 hours of learning of COVID-19 fatality, within 24 hours of COVID-19 hospitalization. When reporting COVID-19 fatalities and in-patient hospitalizations to OSHA in accordance with paragraph (r)(1) of this section, the employer must follow the requirements in 29 CFR part 1904.39, except for 29 CFR part 1904.39(a)(1) and (2) and (b)(6).
- §1910.502(s) *Dates*—The COVID-19 ETS is effective June 21, 2021, Employers must comply with all requirements of the ETS except paragraphs (i), (k) and (n) by July 6, 2021. Employers must comply with paragraphs (i), (k), and (n) by July 21, 2021.

If the Board adopts the federal COVID-19 ETS, it will be effective on August 2, 2021. Virginia employers must comply with all the requirements of the COVID-19 ETS except paragraphs (i), (k) and (n) by August 17, 2021. Employers must comply with paragraphs (i), (k), and (n) by September 1, 2021.

§1910.504 Mini Respiratory Program

- §1910.504(a) *Scope and application*—section only applies to respirator use in accordance with §1910.502(f)(4)
- §1910.504(b) *Definitions*—contains definitions applying to §1910.504
- §1910.504(c) *Respirators provided by employees*—contains requirement that employer provide employee copy of notice detailing how:
 - the user should follow all instructions provided by manufacturer on use, maintenance and cleaning
 - employee should keep track of their own respirator and not use someone else’s mistakenly, and
 - not to use your own respirator where other workplace hazards require use of a respirator—the employer must provide this respirator.
- §1910.504(d) *Respirators provided by employers*—Employers must train employees on how to properly wear, inspect, put on, and remove respirators. Employer must also train on the limitations and capabilities of respirator, procedures for storing and maintaining respirator, and how to perform a seal check. This section also contains provisions on how to reuse respirators.
- §1910.504(e) *Effective date*—This section is effective as of June 21, 2021.

- §1910.505 *Severability*—Each section of this subpart U, and each provision within those sections, is separate and severable from the other sections and provisions. If any provision of this subpart is held to be invalid or unenforceable on its face, or as applied to any person, entity, or circumstance, or is stayed or enjoined, that provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event the provision shall be severable from this subpart and shall not affect the remainder of the subpart.

§1910.509 Incorporation by Reference.

- §1910.509(a)-(d) incorporates some CDC documents, List N—Disinfectants for COVID-19 from the EPA and several ANSI standards.

VII. State Plan requirements and Federal OSHA’s plan to Adjust the COVID-19 ETS as Necessary

A. State Plan Requirements

When federal OSHA promulgates an emergency temporary standard, States and U.S. Territories with their own OSHA-approved occupational safety and health plans (“State Plans”) must either amend their standards to be identical or “at least as effective as” the new standard, or show that an existing State Plan standard covering this area is “at least as effective” as the new Federal standard. 29 CFR 1953.5(b).

Adoption of the COVID-19 ETS by State Plans must be completed within 30 days of the promulgation date of the final Federal rule, and State Plans must notify Federal OSHA of the action they will take within 15 days. The State Plan standard must remain in effect for the duration of the Federal COVID-19 ETS.

B. Federal OSHA Plans to Adjust the COVID-19 ETS as Necessary.

Federal OSHA finds it necessary to adopt the COVID-19 ETS, but plans to adjust as conditions change. As more of the workforce becomes vaccinated and the post-vaccination evidence base continues to grow, and the CDC updates its guidance, federal OSHA will withdraw or modify the COVID-19 ETS to the extent the workplace hazard is substantially diminished in the settings covered by this COVID-19 ETS. Federal OSHA expects to revisit the COVID-19 ETS every 30 days.

VIII. Impact

A. Impact on Employers

Federal OSHA projects the net total effect of the Occupational Exposure to COVID-19; Emergency Temporary Standard will result in additional costs for employers, but also a net benefit. The costs to employers include: developing a COVID-19 plan, patient screening and management, respiratory protection, training, ventilation, health screening and medical management costs, physical barriers and plexiglass, physical distancing, cleaning and disinfecting, hand hygiene, recordkeeping, reporting, and MRP costs. The benefits stem mainly from infections prevented and deaths prevented.

B. Impact on Employees

The COVID-19 ETS will provide greater protections for healthcare workers from occupational exposure to COVID-19 in settings where people with COVID-19 are reasonably expected to be present. In turn an uninfected health care worker cannot infect others in the community, resulting in better control of the pandemic overall.

In addition, by providing paid leave to get a vaccine and time for potential side effects from the vaccine, the COVID-19 ETS will offer greater access to the vaccine, thereby increasing the total number of healthcare workers vaccinated overall.

C. Impact on the Department of Labor and Industry

It is anticipated that any impact on DOLI resulting from adoption of this emergency standard will be negligible. DOLI developed and adopted its own Emergency Temporary Standard (VOSH ETS) on July 15, 2020 and then the [Final Permanent Standard \(FPS\), Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19 on January 13th, 2021](#).

In a side-by-side comparison of the COVID-19 ETS and the FPS, there were many similar requirements. The Department does not anticipate any substantial additional costs to VOSH. Any costs would be related to training VOSH compliance staff on the differences in the OSHA standard and the VOSH standard.

D. Feasibility

1. Technological Feasibility⁴⁸

⁴⁸ See pgs. 342-413 of the preamble to the COVID-19 ETS for an in depth analysis of the technological feasibility of the COVID-19 ETS.

Federal OSHA has reviewed the requirements imposed by the COVID-19 ETS and has determined that achieving compliance with the rule is technologically feasible for typical operations in the settings that are covered by the COVID-19 ETS. In reaching this determination, OSHA reviewed evidence that shows that healthcare-specific good infection control practices are routinely implemented by employers who have employees in covered settings.

This evidence includes: readily available CDC infection control guidance documents, many of which are COVID-19 specific; regulations issued by the Centers for Medicare & Medicaid Services (CMS), compliance with which is typically required for accreditation of these settings by The Joint Commission; and the application of similar requirements in OSHA's Bloodborne Pathogens Standard, 29 CFR 1910.1030.

Federal OSHA's assessment also analyzed the technological feasibility of complying with the requirements of the COVID-19 ETS for developing a COVID-19 Plan: maintaining physical distancing; installing physical barriers; and ensuring existing ventilation systems are operating as designed.

As noted, the COVID-19 ETS requires employers to develop and implement a COVID-19 plan through a multilayered approach to addressing the spread of COVID-19 by taking feasible measures to reduce or eliminate the transmission of COVID-19. This includes requirements for employers to implement procedures to ensure employees maintain at least 6 feet of physical distancing from others to the extent feasible and, when distancing is not feasible, to install physical barriers, again to the extent feasible. It also allows flexibility in the material of barriers.

The regulatory text allows for alternatives in some situations, and federal OSHA has identified a variety of alternatives that it believes would be technologically feasible in those situations most of the time. There are no technological feasibility barriers related to compliance with requirements in the COVID-19 ETS for facemasks and respirators, cleaning and disinfection, health screening and medical management, or employee notification. Based on the combination of federal OSHA's evaluation of technological feasibility of controls in the various scenarios examined, federal OSHA finds that the COVID-19 ETS is technologically feasible.

2. Economic Feasibility⁴⁹

⁴⁹ See pgs. 414-614 of the preamble to the COVID-19 ETS for an in depth analysis of the economic feasibility of the ETS.

Federal OSHA estimates the costs, benefits, and other impacts anticipated to result from the COVID-19 ETS based on employers achieving full compliance with the requirements of the standard. They do not include prior costs associated with firms whose current practices are already in compliance with the COVID-19 ETS requirements.

To determine whether compliance with the COVID-19 ETS is economically feasible for all affected industries, federal OSHA conducted two screening tests to determine whether the costs of the rule are beneath the threshold level at which the economic viability of an affected industry might be threatened. The two screening tests are the one-percent-of-revenue test and the ten-percent-of-profit test. For those industries with costs beneath both of these threshold levels, the rule was presumed to be economically feasible. Industries that have costs beneath both thresholds for all establishments constitute the majority of industries covered by the COVID-19 ETS.

For industries with costs above one percent of revenues or ten percent of profits, federal OSHA performed additional analysis regarding whether firms would be eligible for scope exemptions to avoid the cost of compliance with the COVID-19 ETS or whether they could generally pass on the compliance costs of the rule in the form of higher prices or if, instead, firms would have to absorb the costs of the rule in the form of lost profits.

Given the fact that all competitors in the industries that had costs above the revenue or profit threshold have to comply with the COVID-19 ETS, OSHA does not expect foreign competition or other factors to restrict the ability of affected firms to pass the costs of the COVID-19 ETS on to consumers through price increases. Federal OSHA concluded that the revenue test is the most appropriate metric to use for determining the economic feasibility of the COVID-19 ETS.

Looking at COVID-19 ETS costs to revenues, OSHA has concluded that complying with the COVID-19 ETS is economically feasible for all covered industries in their entirety. Furthermore, none of the economic impacts on small or very small entities are such as to threaten the structure of any of the covered healthcare industries. In addition, it is important to note that the costs of compliance with the COVID-19 ETS will only affect revenues and profits for the period during which the COVID-19 ETS is in effect, which is expected to be at most 6 months, so it will be easier for employers to withstand the impact of any additional costs for this time period as opposed to absorbing ongoing costs typically required by rulemakings.

Finally, OSHA notes that most of the NAICS that failed one or both of the

screens would not have done so if federal OSHA followed its normal analysis of comparing costs to annual profit and revenue, as opposed to only 6 months of profits and revenue. Under a one-year timeframe of revenues and costs, the economic impacts of the COVID-19 ETS would have been cut in half.

The table below provides a summary of Federal OSHA’s best estimate of the costs and benefits of the rule using a discount rate of 3 percent.

Costs		
COVID-19 Plan		\$1,198,482,522
Patient Screening and Management		\$1,245,401,751
Respiratory Protection		\$732,594,291
Training		\$396,046,226
Ventilation		\$30,554,935
Health Screening and Medical Management Costs		\$83,121,853
Physical Barriers and Plexiglass		\$57,407,631
Physical Distancing		\$11,270,696
Cleaning and Disinfecting		\$5,902,432
Hand Hygiene		\$5,800,000
Recordkeeping		\$13,207,068
Reporting		\$129,467
MRP Costs		\$189,726,559
Total Costs		\$3,969,645,432
Benefits	Cases	
Infections Prevented	295,284	19,300,929,013
Deaths Prevented	776	7,550,800,224
		\$26,851,729,237
Net Benefits		\$22,882,083,805

Note: In a true benefit-cost analysis, the costs to all parties (e.g., employers, employees, governments) are included. Throughout OSHA’s economic feasibility analysis in this rule, there are places where OSHA estimates there are no costs borne by employers. This does not necessarily mean that there are no costs or burdens imposed on others as might be considered in a true benefit-cost analysis, but these potential other costs do not need to be considered as part of OSHA’s analysis of the economic feasibility to *employers*.

Using federal OSHA’s estimate of the costs and benefits as a basis, Table I.-2 provides an estimate of Virginia’s costs and benefits of the rule using a discount rate of 3 percent.

Virginia’s Costs		
COVID-19 Plan		\$32,179,256
Patient Screening and Management		\$33,439,037
Respiratory Protection		\$19,670,157
Training		\$10,633,841
Ventilation		\$820,400
Health Screening and Medical Management Costs		\$223,182
Physical Barriers and Plexiglass		\$1,541,395
Physical Distancing		\$302,618
Cleaning and Disinfecting		\$158,480
Hand Hygiene		\$155,730
Recordkeeping		\$354,610
Reporting		\$3,476
MRP Costs		\$5,094,159
Total Costs for Virginia		\$106,584,980
Virginia Benefits		
	Cases	
Infections Prevented	7,928	518,229,944
Deaths Prevented	21	202,738,986
		\$720,968,930
Virginia Net Benefits		\$614,383,950

To calculate Virginia’s cost, Virginia uses the formula (federal costs provided) x .02685= Virginia’s costs.

DOLI developed and adopted its own Emergency Temporary Standard (VOSH ETS) on July 15, 2020 and then the [Final Permanent Standard \(FPS\), Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19 on January 13th, 2021](#), both of which were applicable to employees and employers in healthcare services and healthcare support services.

In a side-by-side comparison of the COVID-19 ETS and the FPS (See Attachment A), there were many similar requirements. It is anticipated that the compliance costs associated with the COVID-19 ETS for covered Virginia employers who are already in compliance with the FPS will be lessened based on the mitigation strategies already implemented.

Based upon the analysis above, Federal OSHA finds the COVID-19 ETS to be both technologically and economically feasible.

Contact Person:

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RECOMMENDED ACTION

Staff of the Department of Labor and Industry recommends that the Safety and Health Codes Board adopt the federal COVID-19 Emergency Temporary Standard, 1910.502, *et seq.*, applicable to all settings where any employee provides healthcare services or healthcare support services, with an effective date of August 2, 2021 and which shall expire within six months or when repealed by the Board, whichever occurs first.

The Department also recommends that the Board state in any motion it may make to adopt this standard that should the federal COVID-19 Emergency Temporary Standard, 1910.502, *et seq.*, applicable to settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board and take effect, application of Virginia's 16VAC-25-220, except for 16VAC-25-220-40 B.7.d and e, and 16VAC25-220-90, to such covered employers and employees subject to the standard shall be suspended while the federal COVID-19 Emergency Temporary Standard remains in effect.

The Department further recommends that the Board state in any motion it may make to adopt this standard that should the federal COVID-19 Emergency Temporary Standard, 1910.502, *et seq.*, applicable to settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed or invalidated by a state or federal court, the provisions of Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required.

The Department further recommends that the Board state in any motion it may make to adopt this standard that should the federal COVID-19 Emergency Temporary Standard, 1910.502, *et seq.*, applicable to all settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed by federal OSHA, or otherwise revoked, repealed, declared unenforceable, or permitted to expire, the Virginia Safety and Health Codes Board shall within 30 days notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, or whether it should be revoked.

The Department also recommends that the Board state in any motion it may make to adopt this standard that it will receive, consider, and respond to petitions by any interested person at any time with respect to reconsideration or revision of this or any other regulation.

Occupational Exposure to COVID-19

Emergency Temporary Standard

As Adopted by the

Safety and Health Codes Board

Date: _____



VIRGINIA OCCUPATIONAL SAFETY AND HEALTH PROGRAM

VIRGINIA DEPARTMENT OF LABOR AND INDUSTRY

Effective Date: _____

16VAC25-90-1910.502; 16 VAC25-90-1910.504; 16 VAC25-90-1910.505; 16 VAC25-90-1910.509

When the regulations as set forth in federal OSHA’s Emergency Temporary Standard for Occupational Exposure to COVID-19, part 1910 is applied to the Commissioner of the Department of Labor and Industry and/or to Virginia employers, the following federal terms shall be considered to read as below:

Federal Terms

VOSH Equivalent

29 CFR

VOSH Standard

Assistant Secretary

Commissioner of Labor and Industry

Agency

Department

June 21, 2021

August 2, 2021

877-889-5627). Due to copyright issues, OSHA cannot post consensus standards on the OSHA website or through www.regulations.gov.

List of Subjects in 29 CFR Part 1910

COVID-19, Disease, Health facilities, Health, Healthcare, Incorporation by reference, Occupational health and safety, Public health, Quarantine, Reporting and recordkeeping requirements, Respirators, SARS-CoV-2, Telework, Vaccines, Viruses.

Authority and Signature

James S. Frederick, Acting Assistant Secretary of Labor for Occupational Safety and Health, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210, authorized the preparation of this document pursuant to the following authorities: Sections 4, 6, and 8 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 653, 655, 657); Secretary of Labor's Order 8-2020 (85 FR 58393 (Sept. 18, 2020)); 29 CFR part 1911; and 5 U.S.C. 553.

James S. Frederick,

Acting Assistant Secretary of Labor for Occupational Safety and Health.

For the reasons set forth in the preamble, chapter XVII of title 29 of the Code of Federal Regulations is amended as follows:

PART 1910—OCCUPATIONAL SAFETY AND HEALTH STANDARDS

■ 1. Add subpart U to read as follows:

Subpart U—COVID-19 Emergency Temporary Standard

Sec.

1910.502 Healthcare.
1910.504 Mini Respiratory Protection Program.
1910.505 Severability.
1910.509 Incorporation by Reference.

Authority: 29 U.S.C. 653, 655, and 657; Secretary of Labor's Order No. 8-2020 (85 FR 58393); 29 CFR part 1911; and 5 U.S.C. 553.

§ 1910.502 Healthcare.

(a) *Scope and application.* (1) Except as otherwise provided in this paragraph, this section applies to all settings where any employee provides healthcare services or healthcare support services.

(2) This section does not apply to the following:

- (i) The provision of first aid by an employee who is not a licensed healthcare provider;
- (ii) The dispensing of prescriptions by pharmacists in retail settings;
- (iii) Non-hospital ambulatory care settings where all non-employees are screened prior to entry and people with

suspected or confirmed COVID-19 are not permitted to enter those settings;

(iv) Well-defined hospital ambulatory care settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings;

(v) Home healthcare settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not present;

(vi) Healthcare support services not performed in a healthcare setting (e.g., off-site laundry, off-site medical billing); or

(vii) Telehealth services performed outside of a setting where direct patient care occurs.

Note to paragraph (a)(2). OSHA does not intend to preclude the employers of employees who are unable to be vaccinated from the scope exemption in paragraphs (a)(2)(iv) and (v) of this section. Under various anti-discrimination laws, workers who cannot be vaccinated because of medical conditions, such as allergies to vaccine ingredients, or certain religious beliefs may ask for a reasonable accommodation from their employer. Accordingly, where an employer reasonably accommodates an employee who is unable to be vaccinated in a manner that does not expose the employee to COVID-19 hazards (e.g., telework, working in isolation), that employer may be within the scope exemption in paragraphs (a)(2)(iv) and (v) of this section.

(3)(i) Where a healthcare setting is embedded within a non-healthcare setting (e.g., medical clinic in a manufacturing facility, walk-in clinic in a retail setting), this section applies only to the embedded healthcare setting and not to the remainder of the physical location.

(ii) Where emergency responders or other licensed healthcare providers enter a non-healthcare setting to provide healthcare services, this section applies only to the provision of the healthcare services by that employee.

(4) In well-defined areas where there is no reasonable expectation that any person with suspected or confirmed COVID-19 will be present, paragraphs (f), (h), and (i) of this section do not apply to employees who are fully vaccinated.

Note 1 to paragraph (a). Nothing in this section is intended to limit state or local government mandates or guidance (e.g., executive order, health department order) that go beyond the requirements of and are not inconsistent with this section.

Note 2 to paragraph (a): Employers are encouraged to follow public health guidance from the Centers for Disease Control and Prevention (CDC) even when not required by this section.

(b) *Definitions.* The following definitions apply to this section:

Aerosol-generating procedure means a medical procedure that generates aerosols that can be infectious and are of respirable size. For the purposes of this section, only the following medical procedures are considered aerosol-generating procedures: Open suctioning of airways; sputum induction; cardiopulmonary resuscitation; endotracheal intubation and extubation; non-invasive ventilation (e.g., BiPAP, CPAP); bronchoscopy; manual ventilation; medical/surgical/postmortem procedures using oscillating bone saws; and dental procedures involving: Ultrasonic scalars; high-speed dental handpieces; air/water syringes; air polishing; and air abrasion.

Airborne infection isolation room (AIIR) means a dedicated negative pressure patient-care room, with special air handling capability, which is used to isolate persons with a suspected or confirmed airborne-transmissible infectious disease. AIIRs include both permanent rooms and temporary structures (e.g., a booth, tent or other enclosure designed to operate under negative pressure).

Ambulatory care means healthcare services performed on an outpatient basis, without admission to a hospital or other facility. It is provided in settings such as: Offices of physicians and other health care professionals; hospital outpatient departments; ambulatory surgical centers; specialty clinics or centers (e.g., dialysis, infusion, medical imaging); and urgent care clinics. Ambulatory care does not include home healthcare settings for the purposes of this section.

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

Clean/cleaning means the removal of dirt and impurities, including germs, from surfaces using soap and water or other cleaning agents. Cleaning alone reduces germs on surfaces by removing contaminants and may also weaken or damage some of the virus particles, which decreases risk of infection from surfaces.

Close contact means being within 6 feet of any other person for a cumulative total of 15 minutes or more over a 24-hour period during that person's potential period of transmission. The potential transmission period runs from 2 days before the person felt sick (or, for asymptomatic people, 2 days prior to test specimen collection) until the time the person is isolated.

Common areas means indoor or outdoor locations under the control of the employer that more than one person may use or where people congregate (e.g., building lobbies, reception areas, waiting rooms, restrooms, break rooms, eating areas, conference rooms).

COVID-19 (Coronavirus Disease 2019) means the respiratory disease caused by SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2). For clarity and ease of reference, this section refers to "COVID-19" when describing exposures or potential exposures to SARS-CoV-2.

COVID-19 positive and confirmed COVID-19 refer to a person who has a confirmed positive test for, or who has been diagnosed by a licensed healthcare provider with, COVID-19.

COVID-19 symptoms mean the following: Fever or chills; cough; shortness of breath or difficulty breathing; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

COVID-19 test means a test for SARS-CoV-2 that is:

(i) Cleared or approved by the U.S. Food and Drug Administration (FDA) or is authorized by an Emergency Use Authorization (EUA) from the FDA to diagnose current infection with the SARS-CoV-2 virus; and

(ii) Administered in accordance with the FDA clearance or approval or the FDA EUA as applicable.

Direct patient care means hands-on, face-to-face contact with patients for the purpose of diagnosis, treatment, and monitoring.

Disinfect/disinfection means using an EPA-registered, hospital-grade disinfectant on EPA's "List N" (incorporated by reference, § 1910.509), in accordance with manufacturers' instructions to kill germs on surfaces.

Elastomeric respirator means a tight-fitting respirator with a facepiece that is made of synthetic or rubber material that permits it to be disinfected, cleaned, and reused according to manufacturer's instructions. It is equipped with a replaceable cartridge(s), canister(s), or filter(s).

Facemask means a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as "medical procedure masks."

Face shield means a device, typically made of clear plastic, that:

(i) Is certified to ANSI/ISEA Z87.1 (incorporated by reference, § 1910.509); or

(ii) Covers the wearer's eyes, nose, and mouth to protect from splashes, sprays, and spatter of body fluids, wraps around the sides of the wearer's face (i.e., temple-to-temple), and extends below the wearer's chin.

Filtering facepiece respirator means a negative pressure particulate respirator with a non-replaceable filter as an integral part of the facepiece or with the entire facepiece composed of the non-replaceable filtering medium.

Fully vaccinated means 2 weeks or more following the final dose of a COVID-19 vaccine.

Hand hygiene means the cleaning and/or disinfecting of one's hands by using standard handwashing methods with soap and running water or an alcohol-based hand rub that is at least 60% alcohol.

Healthcare services mean services that are provided to individuals by professional healthcare practitioners (e.g., doctors, nurses, emergency medical personnel, oral health professionals) for the purpose of promoting, maintaining, monitoring, or restoring health. Healthcare services are delivered through various means including: Hospitalization, long-term care, ambulatory care, home health and hospice care, emergency medical response, and patient transport. For the purposes of this section, healthcare services include autopsies.

Healthcare support services mean services that facilitate the provision of healthcare services. Healthcare support services include patient intake/admission, patient food services, equipment and facility maintenance, housekeeping services, healthcare laundry services, medical waste handling services, and medical equipment cleaning/reprocessing services.

High-touch surfaces and equipment means any surface or piece of equipment that is repeatedly touched by more than one person (e.g., doorknobs, light switches, countertops, handles, desks, tables, phones, keyboards, tools, toilets, faucets, sinks, credit card terminals, touchscreen-enabled devices).

Physical location means a site (including outdoor and indoor areas, a structure, or a group of structures) or an area within a site where work or any work-related activity (e.g., taking breaks, going to the restroom, eating, entering, or exiting work) occurs. A physical location includes the entirety of any space associated with the site (e.g., workstations, hallways, stairwells, breakrooms, bathrooms, elevators) and any other space that an employee might occupy in arriving, working, or leaving.

Powered air-purifying respirator (PAPR) means an air-purifying respirator that uses a blower to force the ambient air through air-purifying elements to the inlet covering.

Respirator means a type of personal protective equipment (PPE) that is certified by NIOSH under 42 CFR part 84 or is authorized under an EUA by the FDA. Respirators protect against airborne hazards by removing specific air contaminants from the ambient (surrounding) air or by supplying breathable air from a safe source. Common types of respirators include filtering facepiece respirators, elastomeric respirators, and PAPRs. Face coverings, facemasks, and face shields are not respirators.

Screen means asking questions to determine whether a person is COVID-19 positive or has symptoms of COVID-19.

Surgical mask means a mask that covers the user's nose and mouth and provides a physical barrier to fluids and particulate materials. The mask meets certain fluid barrier protection standards and Class I or Class II flammability tests. Surgical masks are generally regulated by FDA as Class II devices under 21 CFR 878.4040—Surgical apparel.

Vaccine means a biological product authorized or licensed by the FDA to prevent or provide protection against COVID-19, whether the substance is administered through a single dose or a series of doses.

Workplace means a physical location (e.g., fixed, mobile) where the employer's work or operations are performed.

(c) **COVID-19 plan.** (1) The employer must develop and implement a COVID-19 plan for each workplace. If the employer has multiple workplaces that are substantially similar, its COVID-19 plan may be developed by workplace type rather than by individual workplace so long as all required site-specific information is included in the plan.

Note to paragraph (c)(1). For those employers who do not already have a COVID-19 plan in place, OSHA's website contains significant compliance assistance materials, including a model plan.

(2) If the employer has more than 10 employees, the COVID-19 plan must be written.

(3) The employer must designate one or more workplace COVID-19 safety coordinators to implement and monitor the COVID-19 plan developed under this section. The COVID-19 safety coordinator(s) must be knowledgeable in infection control principles and

practices as they apply to the workplace and employee job operations. The identity of the safety coordinator(s) must be documented in any written COVID-19 plan. The safety coordinator(s) must have the authority to ensure compliance with all aspects of the COVID-19 plan.

(4)(i) The employer must conduct a workplace-specific hazard assessment to identify potential workplace hazards related to COVID-19.

(ii) In order for an employer to be exempt from providing controls in a well-defined area under paragraph (a)(4) of this section based on employees' fully vaccinated status, the COVID-19 plan must include policies and procedures to determine employees' vaccination status.

(5) The employer must seek the input and involvement of non-managerial employees and their representatives, if any, in the hazard assessment and the development and implementation of the COVID-19 plan.

(6) The employer must monitor each workplace to ensure the ongoing effectiveness of the COVID-19 plan and update it as needed.

(7) The COVID-19 plan must address the hazards identified by the assessment required by paragraph (c)(4) of this section, and include policies and procedures to:

(i) Minimize the risk of transmission of COVID-19 for each employee, as required by paragraphs (d) through (n) of this section;

Note to paragraph (c)(7)(i). Although the employer's COVID-19 plan must account for the potential COVID-19 exposures to each employee, the plan can do so generally and need not address each employee individually.

(ii) Effectively communicate and coordinate with other employers:

(A) When employees of different employers share the same physical location, each employer must effectively communicate its COVID-19 plan to all other employers, coordinate to ensure that each of its employees is protected as required by this section, and adjust its COVID-19 plan to address any particular COVID-19 hazards presented by the other employees. This requirement does not apply to delivery people, messengers, and other employees who only enter a workplace briefly to drop off or pick up items.

(B) An employer with one or more employees working in a physical location controlled by another employer must notify the controlling employer when those employees are exposed to conditions at that location that do not meet the requirements of this section; and

(iii) Protect employees who in the course of their employment enter into private residences or other physical locations controlled by a person not covered by the OSH Act (e.g., homeowners, sole proprietors). This must include procedures for employee withdrawal from that location if those protections are inadequate.

Note to paragraph (c). The employer may include other policies, procedures, or information necessary to comply with any applicable federal, state, or local public health laws, standards, and guidelines in their COVID-19 plan.

(d) *Patient screening and management.* In settings where direct patient care is provided, the employer must:

(1) Limit and monitor points of entry to the setting. This provision does not apply where emergency responders or other licensed healthcare providers enter a non-healthcare setting to provide healthcare services.

(2) Screen and triage all clients, patients, residents, delivery people and other visitors, and other non-employees entering the setting.

(3) Implement other applicable patient management strategies in accordance with CDC's "COVID-19 Infection Prevention and Control Recommendations" (incorporated by reference, § 1910.509).

Note to paragraph (d). The employer is encouraged to use telehealth services where available and appropriate in order to limit the number of people entering the workplace.

(e) *Standard and Transmission-Based Precautions.* Employers must develop and implement policies and procedures to adhere to Standard and Transmission-Based Precautions in accordance with CDC's "Guidelines for Isolation Precautions" (incorporated by reference, § 1910.509).

(f) *Personal protective equipment (PPE)—(1) Facemasks.* (i) Employers must provide, and ensure that employees wear, facemasks that meet the definition in paragraph (b) of this section; and

(ii) The employer must ensure a facemask is worn by each employee over the nose and mouth when indoors and when occupying a vehicle with other people for work purposes. The employer must provide a sufficient number of facemasks to each employee to comply with this paragraph and must ensure that each employee changes them at least once per day, whenever they are soiled or damaged, and more frequently as necessary (e.g., patient care reasons).

(iii) The following are exceptions to the requirements for facemasks in paragraph (f)(1)(ii) of this section:

(A) When an employee is alone in a room.

(B) While an employee is eating and drinking at the workplace, provided each employee is at least 6 feet away from any other person, or separated from other people by a physical barrier.

(C) When employees are wearing respiratory protection in accordance with § 1910.134 or paragraph (f) of this section.

(D) When it is important to see a person's mouth (e.g., communicating with an individual who is deaf or hard of hearing) and the conditions do not permit a facemask that is constructed of clear plastic (or includes a clear plastic window). In such situations, the employer must ensure that each employee wears an alternative to protect the employee, such as a face shield, if the conditions permit it.

(E) When employees cannot wear facemasks due to a medical necessity, medical condition, or disability as defined in the Americans with Disabilities Act (42 U.S.C. 12101 *et seq.*), or due to a religious belief. Exceptions must be provided for a narrow subset of persons with a disability who cannot wear a facemask or cannot safely wear a facemask, because of the disability, as defined in the Americans with Disabilities Act (42 U.S.C. 12101 *et seq.*), including a person who cannot independently remove the facemask. The remaining portion of the subset who cannot wear a facemask may be exempted on a case-by-case basis as required by the Americans with Disabilities Act and other applicable laws. In all such situations, the employer must ensure that any such employee wears a face shield for the protection of the employee, if their condition or disability permits it. Accommodations may also need to be made for religious beliefs consistent with Title VII of the Civil Rights Act.

(F) When the employer can demonstrate that the use of a facemask presents a hazard to an employee of serious injury or death (e.g., arc flash, heat stress, interfering with the safe operation of equipment). In such situations, the employer must ensure that each employee wears an alternative to protect the employee, such as a face shield, if the conditions permit it. Any employee not wearing a facemask must remain at least 6 feet away from all other people unless the employer can demonstrate it is not feasible. The employee must resume wearing a facemask when not engaged in the

activity where the facemask presents a hazard.

Note to paragraph (f)(1)(iii)(F). With respect to paragraphs (f)(1)(iii)(D) through (F) of this section, the employer may determine that the use of face shields, without facemasks, in certain settings is not appropriate due to other infection control concerns.

(iv) Where a face shield is required to comply with this paragraph or is otherwise required by the employer, the employer must ensure that face shields are cleaned at least daily and are not damaged. When an employee provides a face shield that meets the definition in paragraph (b) of this section, the employer may allow the employee to use it and is not required to reimburse the employee for that face shield.

(2) Respirators and other PPE for exposure to people with suspected or confirmed COVID-19. When employees have exposure to a person with suspected or confirmed COVID-19, the employer must provide:

(i) A respirator to each employee and ensure that it is provided and used in accordance with § 1910.134 and

(ii) Gloves, an isolation gown or protective clothing, and eye protection to each employee and ensure that the PPE is used in accordance with subpart I of this part.

Note to paragraph (f)(2). When there is a limited supply of filtering facepiece respirators, employers may follow the CDC's "Strategies for Optimizing the Supply of N95 Respirators" (available at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html>). Where possible, employers are encouraged to select elastomeric respirators or PAPRs instead of filtering facepiece respirators to prevent shortages and supply chain disruption.

(3) Respirators and other PPE during aerosol-generating procedures. For aerosol-generating procedures performed on a person with suspected or confirmed COVID-19, the employer must provide:

(i) A respirator to each employee and ensure that it is provided and used in accordance with § 1910.134; and

(ii) Gloves, an isolation gown or protective clothing, and eye protection to each employee and ensure that the PPE is used in accordance with subpart I of this part.

Note 1 to paragraph (f)(3). For aerosol-generating procedures on a person suspected or confirmed with COVID-19, employers are encouraged to select elastomeric respirators or PAPRs instead of filtering facepiece respirators.

Note 2 to paragraph (f)(3). Additional requirements specific to aerosol-generating procedures on people with suspected or

confirmed COVID-19 are contained in paragraph (g) of this section.

(4) Use of respirators when not required. (i) The employer may provide a respirator to the employee instead of a facemask as required by paragraph (f)(1) of this section. In such circumstances, the employer must comply with § 1910.504.

(ii) Where the employer provides the employee with a facemask as required by paragraph (f)(1) of this section, the employer must permit the employee to wear their own respirator instead of a facemask. In such circumstances, the employer must also comply with § 1910.504.

(5) Respirators and other PPE based on Standard and Transmission-Based Precautions. The employer must provide protective clothing and equipment (e.g., respirators, gloves, gowns, goggles, face shields) to each employee in accordance with Standard and Transmission-Based Precautions in healthcare settings in accordance with CDC's "Guidelines for Isolation Precautions" (incorporated by reference, § 1910.509) and ensure that the protective clothing and equipment is used in accordance with subpart I of this part.

(g) *Aerosol-generating procedures on a person with suspected or confirmed COVID-19.* When an aerosol-generating procedure is performed on a person with suspected or confirmed COVID-19:

(1) The employer must limit the number of employees present during the procedure to only those essential for patient care and procedure support.

(2) The employer must ensure that the procedure is performed in an existing AIIR, if available.

(3) After the procedure is completed, the employer must clean and disinfect the surfaces and equipment in the room or area where the procedure was performed.

Note to paragraph (g). Respirators and other PPE requirements during aerosol-generating procedures are contained in paragraph (f)(3) of this section.

(h) *Physical distancing.* (1) The employer must ensure that each employee is separated from all other people by at least 6 feet when indoors unless the employer can demonstrate that such physical distancing is not feasible for a specific activity (e.g., hands-on medical care). This provision does not apply to momentary exposure while people are in movement (e.g., passing in hallways or aisles).

(2) When the employer establishes it is not feasible for an employee to maintain a distance of at least 6 feet from all other people, the employer

must ensure that the employee is as far apart from all other people as feasible.

Note to paragraph (h). Physical distancing can include methods such as: Telehealth; telework or other remote work arrangements; reducing the number of people, including non-employees, in an area at one time; visual cues such as signs and floor markings to indicate where employees and others should be located or their direction and path of travel; staggered arrival, departure, work, and break times; and adjusted work processes or procedures to allow greater distance between employees.

(i) *Physical barriers.* At each fixed work location outside of direct patient care areas (e.g., entryway/lobby, check-in desks, triage, hospital pharmacy windows, bill payment) where each employee is not separated from all other people by at least 6 feet of distance, the employer must install cleanable or disposable solid barriers, except where the employer can demonstrate it is not feasible. The barrier must be sized (e.g., height and width) and located to block face-to-face pathways between individuals based on where each person would normally stand or sit. The barrier may have a pass-through space at the bottom for objects and merchandise.

Note to paragraph (i). Physical barriers are not required in direct patient care areas or resident rooms.

(j) *Cleaning and disinfection.* (1) In patient care areas, resident rooms, and for medical devices and equipment, the employer must follow standard practices for cleaning and disinfection of surfaces and equipment in accordance with CDC's "COVID-19 Infection Prevention and Control Recommendations" and CDC's "Guidelines for Environmental Infection Control," pp. 86-103, 147-149 (both incorporated by reference, § 1910.509).

(2) In all other areas, the employer must:

(i) Clean high-touch surfaces and equipment at least once a day, following manufacturers' instructions for application of cleaners; and

(ii) When the employer is aware that a person who is COVID-19 positive has been in the workplace within the last 24 hours, clean and disinfect, in accordance with CDC's "Cleaning and Disinfecting Guidance" (incorporated by reference, § 1910.509), any areas, materials, and equipment under the employer's control that have likely been contaminated by the person who is COVID-19 positive (e.g., rooms they occupied, items they touched).

(3) The employer must provide alcohol-based hand rub that is at least 60% alcohol or provide readily accessible hand washing facilities.

(k) *Ventilation.* (1) Employers who own or control buildings or structures with an existing heating, ventilation, and air conditioning (HVAC) system(s) must ensure that:

- (i) The HVAC system(s) is used in accordance with the HVAC manufacturer's instructions and the design specifications of the HVAC system(s);
- (ii) The amount of outside air circulated through its HVAC system(s) and the number of air changes per hour are maximized to the extent appropriate;
- (iii) All air filters are rated Minimum Efficiency Reporting Value (MERV) 13 or higher, if compatible with the HVAC system(s). If MERV-13 or higher filters are not compatible with the HVAC system(s), employers must use filters with the highest compatible filtering efficiency for the HVAC system(s);
- (iv) All air filters are maintained and replaced as necessary to ensure the proper function and performance of the HVAC system(s); and
- (v) All intake ports that provide outside air to the HVAC system(s) are cleaned, maintained, and cleared of any debris that may affect the function and performance of the HVAC system(s).

(2) Where the employer has an existing AHIR, the employer must maintain and operate it in accordance with its design and construction criteria.

Note 1 to paragraph (k). This section does not require installation of new HVAC systems or AHIRs to replace or augment functioning systems.

Note 2 to paragraph (k). In addition to the requirements for existing HVAC systems and AHIRs, all employers should also consider other measures to improve ventilation in accordance with "CDC's Ventilation Guidance," (available at www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html) (e.g., opening windows and doors). This could include maximizing ventilation in buildings without HVAC systems or in vehicles.

(l) *Health screening and medical management—(1) Screening.* (i) The employer must screen each employee before each work day and each shift. Screening may be conducted by asking employees to self-monitor before reporting to work or may be conducted in-person by the employer.

(ii) If a COVID-19 test is required by the employer for screening purposes, the employer must provide the test to each employee at no cost to the employee.

(2) *Employee notification to employer of COVID-19 illness or symptoms.* The employer must require each employee to promptly notify the employer when the employee:

- (i) Is COVID-19 positive (*i.e.*, confirmed positive test for, or has been diagnosed by a licensed healthcare provider with, COVID-19); or
- (ii) Has been told by a licensed healthcare provider that they are suspected to have COVID-19; or
- (iii) Is experiencing recent loss of taste and/or smell with no other explanation; or
- (iv) Is experiencing both fever (≥ 100.4 °F) and new unexplained cough associated with shortness of breath.

(3) *Employer notification to employees of COVID-19 exposure in the workplace.*

(i) Except as provided for in paragraph (l)(3)(iii) of this section, when the employer is notified that a person who has been in the workplace(s) (including employees, clients, patients, residents, vendors, contractors, customers, delivery people and other visitors, or other non-employees) is COVID-19 positive, the employer must, within 24 hours:

(A) Notify each employee who was not wearing a respirator and any other required PPE and has been in close contact with that person in the workplace. The notification must state the fact that the employee was in close contact with someone with COVID-19 along with the date(s) that contact occurred.

(B) Notify all other employees who were not wearing a respirator and any other required PPE and worked in a well-defined portion of a workplace (e.g., a particular floor) in which that person was present during the potential transmission period. The potential transmission period runs from 2 days before the person felt sick (or, for asymptomatic people, 2 days prior to test specimen collection) until the time the person is isolated. The notification must specify the date(s) the person with COVID-19 was in the workplace during the potential transmission period.

(C) Notify other employers whose employees were not wearing respirators and any other required PPE and have been in close contact with that person, or worked in a well-defined portion of a workplace (e.g., a particular floor) in which that person was present, during the potential transmission period. The potential transmission period runs from 2 days before the person felt sick (or, for asymptomatic people, 2 days prior to test specimen collection) until the time the person is isolated. The notification must specify the date(s) the person with COVID-19 was in the workplace during the potential transmission period and the location(s) where the person with COVID-19 was in the workplace.

(ii) The notifications required by paragraph (l)(3)(i) of this section must not include any employee's name, contact information (e.g., phone number, email address), or occupation.

(iii) The notification provisions are not triggered by the presence of a patient with confirmed COVID-19 in a workplace where services are normally provided to suspected or confirmed COVID-19 patients (e.g., emergency rooms, urgent care facilities, COVID-19 testing sites, COVID-19 wards in hospitals).

(4) *Medical removal from the workplace.* (i) If the employer knows an employee meets the criteria listed in paragraph (l)(2)(i) of this section, then the employer must immediately remove that employee and keep the employee removed until they meet the return to work criteria in paragraph (l)(6) of this section.

(ii) If the employer knows an employee meets the criteria listed in paragraphs (l)(2)(ii) through (iv) of this section, then the employer must immediately remove that employee and either:

(A) Keep the employee removed until they meet the return to work criteria in paragraph (l)(6) of this section; or

(B) Keep the employee removed and provide a COVID-19 polymerase chain reaction (PCR) test at no cost to the employee.

(1) If the test results are negative, the employee may return to work immediately.

(2) If the test results are positive, the employer must comply with paragraph (l)(4)(i) of this section.

(3) If the employee refuses to take the test, the employer must continue to keep the employee removed from the workplace consistent with paragraph (l)(4)(ii)(A) of this section, but the employer is not obligated to provide medical removal protection benefits in accordance with paragraph (l)(5)(iii) of this section. Absent undue hardship, employers must make reasonable accommodations for employees who cannot take the test for religious or disability-related medical reasons.

Note to paragraph (l)(4)(ii). This partial symptom list in paragraphs (l)(2)(iii) and (l)(2)(iv) of this section informs the employer of the minimum requirements for compliance. The full list of COVID-19 symptoms provided by CDC includes additional symptoms not listed in paragraphs (l)(2)(iii) through (iv) of this section. Employers may choose to remove or test employees with additional symptoms from the CDC list, or refer the employees to a healthcare provider.

(iii)(A) If the employer is required to notify the employee of close contact in

the workplace to a person who is COVID-19 positive in accordance with paragraph (l)(3)(i)(A) of this section, then the employer must immediately remove that employee and either:

(1) Keep the employee removed for 14 days; or

(2) Keep the employee removed and provide a COVID-19 test at least five days after the exposure at no cost to the employee.

(i) If the test results are negative, the employee may return to work after seven days following exposure.

(ii) If the test results are positive, the employer must comply with paragraph (l)(4)(i) of this section.

(iii) If the employee refuses to take the test, the employer must continue to keep the employee removed from the workplace consistent with paragraph (l)(4)(iii)(A)(1) of this section, but the employer is not obligated to provide medical removal protection benefits in accordance with paragraph (l)(5)(iii) of this section. Absent undue hardship, employers must make reasonable accommodations for employees who cannot take the test for religious or disability-related medical reasons, consistent with applicable non-discrimination laws.

(B) Employers are not required to remove any employee who would otherwise be required to be removed under paragraph (i)(4)(iii)(A) of this section if the employee does not experience the symptoms in paragraph (l)(2)(iii) or (iv) of this section and has:

(1) Been fully vaccinated against COVID-19 (*i.e.*, 2 weeks or more following the final dose); or

(2) Had COVID-19 and recovered within the past 3 months.

(iv) Any time an employee is required to be removed from the workplace for any reason under paragraph (l)(4) of this section, the employer may require the employee to work remotely or in isolation if suitable work is available.

(5) *Medical removal protection benefits.* (i) Employers with 10 or fewer employees on the effective date of this section are not required to comply with paragraphs (l)(5)(iii) through (iv) of this section.

(ii) When an employer allows an employee to work remotely or in isolation in accordance with paragraph (l)(4)(iv) of this section, the employer must continue to pay the employee the same regular pay and benefits the employee would have received had the employee not been absent from work, until the employee meets the return to work criteria specified in paragraph (l)(4)(iii) or (l)(6) of this section.

(iii) When an employer removes an employee in accordance with paragraph (l)(4) of this section:

(A) The employer must continue to provide the benefits to which the employee is normally entitled and must also pay the employee the same regular pay the employee would have received had the employee not been absent from work, up to \$1,400 per week, until the employee meets the return to work criteria specified in paragraph (l)(4)(iii) or (l)(6) of this section.

(B) For employers with fewer than 500 employees, the employer must pay the employee up to the \$1,400 per week cap but, beginning in the third week of an employee's removal, the amount is reduced to only two-thirds of the same regular pay the employee would have received had the employee not been absent from work, up to \$200 per day (\$1,000 per week in most cases).

(iv) The employer's payment obligation under paragraph (l)(5)(iii) of this section is reduced by the amount of compensation that the employee receives from any other source, such as a publicly or employer-funded compensation program (*e.g.*, paid sick leave, administrative leave), for earnings lost during the period of removal or any additional source of income the employee receives that is made possible by virtue of the employee's removal.

(v) Whenever an employee returns to the workplace after a COVID-19-related workplace removal, that employee must not suffer any adverse action as a result of that removal from the workplace and must maintain all employee rights and benefits, including the employee's right to their former job status, as if the employee had not been removed.

(6) *Return to work.* The employer must make decisions regarding an employee's return to work after a COVID-19-related workplace removal in accordance with guidance from a licensed healthcare provider or CDC's "Isolation Guidance" (incorporated by reference, § 1910.509); and CDC's "Return to Work Healthcare Guidance" (incorporated by reference, § 1910.509).

Note to paragraph (l). OSHA recognizes that CDC's "Strategies to Mitigate Healthcare Personnel Staffing Shortages" (available at www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html) allows elimination of quarantine for certain healthcare workers, but only as a last resort, if the workers' absence would mean there are no longer enough staff to provide safe patient care, specific other amelioration strategies have already been tried, patients have been notified, and workers are utilizing additional PPE at all times.

(m) *Vaccination.* The employer must support COVID-19 vaccination for each

employee by providing reasonable time and paid leave (*e.g.*, paid sick leave, administrative leave) to each employee for vaccination and any side effects experienced following vaccination.

(n) *Training.* (1) The employer must ensure that each employee receives training, in a language and at a literacy level the employee understands, and so that the employee comprehends at least the following:

(i) COVID-19, including how the disease is transmitted (including pre-symptomatic and asymptomatic transmission), the importance of hand hygiene to reduce the risk of spreading COVID-19 infections, ways to reduce the risk of spreading COVID-19 through the proper covering of the nose and mouth, the signs and symptoms of the disease, risk factors for severe illness, and when to seek medical attention;

(ii) Employer-specific policies and procedures on patient screening and management;

(iii) Tasks and situations in the workplace that could result in COVID-19 infection;

(iv) Workplace-specific policies and procedures to prevent the spread of COVID-19 that are applicable to the employee's duties (*e.g.*, policies on Standard and Transmission-Based Precautions, physical distancing, physical barriers, ventilation, aerosol-generating procedures);

(v) Employer-specific multi-employer workplace agreements related to infection control policies and procedures, the use of common areas, and the use of shared equipment that affect employees at the workplace;

(vi) Employer-specific policies and procedures for PPE worn to comply with this section, including:

(A) When PPE is required for protection against COVID-19;

(B) Limitations of PPE for protection against COVID-19;

(C) How to properly put on, wear, and take off PPE;

(D) How to properly care for, store, clean, maintain, and dispose of PPE; and

(E) Any modifications to donning, doffing, cleaning, storage, maintenance, and disposal procedures needed to address COVID-19 when PPE is worn to address workplace hazards other than COVID-19;

(vii) Workplace-specific policies and procedures for cleaning and disinfection;

(viii) Employer-specific policies and procedures on health screening and medical management;

(ix) Available sick leave policies, any COVID-19-related benefits to which the employee may be entitled under

applicable federal, state, or local laws, and other supportive policies and practices (e.g., telework, flexible hours);

(x) The identity of the safety coordinator(s) specified in the COVID-19 plan;

(xi) The requirements of this section; and

(xii) How the employee can obtain copies of this section and any employer-specific policies and procedures developed under this section, including the employer's written COVID-19 plan, if required.

Note to paragraph (n)(1). Employers may rely on training completed prior to the effective date of this section to the extent that it meets the relevant training requirements under this paragraph.

(2) The employer must ensure that each employee receives additional training whenever:

(i) Changes occur that affect the employee's risk of contracting COVID-19 at work (e.g., new job tasks);

(ii) Policies or procedures are changed; or

(iii) There is an indication that the employee has not retained the necessary understanding or skill.

(3) The employer must ensure that the training is overseen or conducted by a person knowledgeable in the covered subject matter as it relates to the employee's job duties.

(4) The employer must ensure that the training provides an opportunity for interactive questions and answers with a person knowledgeable in the covered subject matter as it relates to the employee's job duties.

(o) **Anti-Retaliation.** (1) The employer must inform each employee that:

(i) Employees have a right to the protections required by this section; and

(ii) Employers are prohibited from discharging or in any manner discriminating against any employee for exercising their right to the protections required by this section, or for engaging in actions that are required by this section.

(2) The employer must not discharge or in any manner discriminate against any employee for exercising their right to the protections required by this section, or for engaging in actions that are required by this section.

Note to paragraph (o). In addition, section 11(c) of the OSH Act also prohibits the employer from discriminating against an employee for exercising rights under, or as a result of actions that are required by, this section. That provision of the Act also protects the employee who files a safety and health complaint, or otherwise exercises any rights afforded by the OSH Act.

(p) **Requirements implemented at no cost to employees.** The implementation

of all requirements of this section, with the exception of any employee self-monitoring conducted under paragraph (l)(1)(i) of this section, must be at no cost to employees.

(q) **Recordkeeping.** (1) **Small employer exclusion.** Employers with 10 or fewer employees on the effective date of this section are not required to comply with paragraph (q)(2) or (q)(3) of this section.

(2) **Required records.** Employers with more than 10 employees on the effective date of this section must:

(i) Retain all versions of the COVID-19 plan implemented to comply with this section while this section remains in effect.

(ii) Establish and maintain a COVID-19 log to record each instance identified by the employer in which an employee is COVID-19 positive, regardless of whether the instance is connected to exposure to COVID-19 at work.

(A) The COVID-19 log must contain, for each instance, the employee's name, one form of contact information, occupation, location where the employee worked, the date of the employee's last day at the workplace, the date of the positive test for, or diagnosis of, COVID-19, and the date the employee first had one or more COVID-19 symptoms, if any were experienced.

(B) The information in the COVID-19 log must be recorded within 24 hours of the employer learning that the employee is COVID-19 positive and must be maintained as though it is a confidential medical record and must not be disclosed except as required by this ETS or other federal law.

(C) The COVID-19 log must be maintained and preserved while this section remains in effect.

Note to paragraph (q)(2)(ii): The COVID-19 log is intended to assist employers with tracking and evaluating instances of employees who are COVID-19 positive without regard to whether those employees were infected at work. The tracking will help evaluate potential workplace exposure to other employees.

(3) **Availability of records.** By the end of the next business day after a request, the employer must provide, for examination and copying:

(i) All versions of the written COVID-19 plan to all of the following: Any employees, their personal representatives, and their authorized representatives.

(ii) The individual COVID-19 log entry for a particular employee to that employee and to anyone having written authorized consent of that employee.

(iii) A version of the COVID-19 log that removes the names of employees, contact information, and occupation,

and only includes, for each employee in the COVID-19 log, the location where the employee worked, the last day that the employee was at the workplace before removal, the date of that employee's positive test for, or diagnosis of, COVID-19, and the date the employee first had one or more COVID-19 symptoms, if any were experienced, to all of the following: Any employees, their personal representatives, and their authorized representatives.

(iv) All records required to be maintained by this section to the Assistant Secretary.

Note to paragraph (q). Employers must continue to record all work-related confirmed cases of COVID-19 on their OSHA Forms 300, 300A, and 301, or the equivalent forms, if required to do so under 29 CFR part 1904.

(r) **Reporting COVID-19 fatalities and hospitalizations to OSHA.** (1) The employer must report to OSHA:

(i) Each work-related COVID-19 fatality within 8 hours of the employer learning about the fatality.

(ii) Each work-related COVID-19 inpatient hospitalization within 24 hours of the employer learning about the inpatient hospitalization.

(2) When reporting COVID-19 fatalities and inpatient hospitalizations to OSHA in accordance with paragraph (r)(1) of this section, the employer must follow the requirements in 29 CFR 1904.39, except for 29 CFR 1904.39(a)(1) and (2) and (b)(6).

(s) **Dates.** (1) **Effective date.** This section is effective as of June 21, 2021.

(2) **Compliance dates.** (i) Employers must comply with all requirements of this section, except for requirements in paragraphs (i), (k), and (n) of this section by July 6, 2021.

(ii) Employers must comply with the requirements of this section in paragraphs (i), (k), and (n) of this section by July 21, 2021.

§ 1910.504 Mini Respiratory Protection Program.

(a) **Scope and application.** This section applies only to respirator use in accordance with § 1910.502(f)(4).

(b) **Definitions.** The following definitions apply to this section:

COVID-19 (Coronavirus Disease 2019) means the respiratory disease caused by SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2). For clarity and ease of reference, this section refers to "COVID-19" when describing exposures or potential exposures to SARS-CoV-2.

Elastomeric respirator means a tight-fitting respirator with a facepiece that is made of synthetic or rubber material that permits it to be disinfected, cleaned, and reused according to

manufacturer's instructions. It is equipped with a replaceable cartridge(s), canister(s), or filter(s).

Filtering facepiece respirator means a negative-pressure particulate respirator with a non-replaceable filter as an integral part of the facepiece or with the entire facepiece composed of the non-replaceable filtering medium.

Hand hygiene means the cleaning and/or disinfecting of one's hands by using standard handwashing methods with soap and running water or an alcohol-based hand rub that is at least 60% alcohol.

Respirator means a type of personal protective equipment (PPE) that is certified by the National Institute for Occupational Safety and Health (NIOSH) under 42 CFR part 84 or is authorized under an Emergency Use Authorization (EUA) by the US Food and Drug Administration. Respirators protect against airborne hazards by removing specific air contaminants from the ambient (surrounding) air or by supplying breathable air from a safe source. Common types of respirators include filtering facepiece respirators, elastomeric respirators, and PAPRs. Face coverings, facemasks, and face shields are not respirators.

Powered air-purifying respirator (PAPR) means an air-purifying respirator that uses a blower to force the ambient air through air-purifying elements to the inlet covering.

Tight-fitting respirator means a respirator in which the air pressure inside the facepiece is negative during inhalation with respect to the ambient air pressure outside the respirator (e.g., filtering facepiece).

User seal check means an action conducted by the respirator user to determine if the respirator is properly seated to the face.

(c) **Respirators provided by employees.** Where employees provide and use their own respirators, the employer must provide each employee with the following notice: Respirators can be an effective method of protection against COVID-19 hazards when properly selected and worn. Respirator use is encouraged to provide an additional level of comfort and protection for workers even in circumstances that do not require a respirator to be used. However, if a respirator is used improperly or not kept clean, the respirator itself can become a hazard to the worker. If your employer allows you to provide and use your own respirator, you need to take certain precautions to be sure that the respirator itself does not present a hazard. You should do the following:

(1) Read and follow all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirator's limitations.

(2) Keep track of your respirator so that you do not mistakenly use someone else's respirator.

(3) Do not wear your respirator where other workplace hazards (e.g., chemical exposures) require use of a respirator. In such cases, your employer must provide you with a respirator that is used in accordance with OSHA's respiratory protection standard (29 CFR 1910.134). For more information about using a respirator, see OSHA's respiratory protection safety and health topics page (<https://www.osha.gov/respiratory-protection>).

(d) **Respirators provided by employers.** Where employers provide respirators to their employees, the employer must comply with the following requirements:

(1) **Training.** The employer must ensure that each employee wearing a respirator receives training prior to first use and if they change the type of respirator, in a language and at a literacy level the employee understands, and comprehends at least the following:

(i) How to inspect, put on and remove, and use a respirator;

(ii) The limitations and capabilities of the respirator, particularly when the respirator has not been fit tested;

(iii) Procedures and schedules for storing, maintaining, and inspecting respirators;

(iv) How to perform a user seal check as described in paragraph (d)(2) of this section; and

(v) How to recognize medical signs and symptoms that may limit or prevent the effective use of respirators and what to do if the employee experiences signs and symptoms.

(2) **User seal check.** (i) The employer must ensure that each employee who uses a tight-fitting respirator performs a user seal check to ensure that the respirator is properly seated to the face each time the respirator is put on. Acceptable methods of user seal checks include:

(A) Positive pressure user seal check (i.e., blow air out). Once you have conducted proper hand hygiene and properly donned the respirator, place your hands over the facepiece, covering as much surface area as possible. Exhale gently into the facepiece. The face fit is considered satisfactory if a slight positive pressure is being built up inside the facepiece without any evidence of outward leakage of air at the seal. Examples of evidence that it is leaking could be the feeling of air

movement on your face along the seal of the facepiece, fogging of your glasses, or a lack of pressure being built up inside the facepiece. If the particulate respirator has an exhalation valve, then performing a positive pressure check may not be possible unless the user can cover the exhalation valve. In such cases, a negative pressure check must be performed.

(B) Negative pressure user seal check (i.e., suck air in). Once you have conducted proper hand hygiene and properly donned the respirator, cover the filter surface with your hands as much as possible and then inhale. The facepiece should collapse on your face and you should not feel air passing between your face and the facepiece.

(ii) The employer must ensure that each employee corrects any problems discovered during the user seal check. In the case of either type of user seal check (positive or negative), if air leaks around the nose, use both hands to readjust how the respirator sits on your face or adjust the nosepiece, if applicable. Readjust the straps along the sides of your head until a proper seal is achieved.

Note to paragraph (d)(2). When employees are required to wear a respirator and a problem with the seal check arises due to interference with the seal by an employee's facial hair, employers may provide a different type of respirator to accommodate employees who cannot trim or cut facial hair due to religious belief.

(3) **Reuse of respirators.** (i) The employer must ensure that a filtering facepiece respirator used by a particular employee is only reused by that employee, and only when:

(A) The respirator is not visibly soiled or damaged;

(B) The respirator has been stored in a breathable storage container (e.g., paper bag) for at least five calendar days between use and has been kept away from water or moisture;

(C) The employee does a visual check in adequate lighting for damage to the respirator's fabric or seal;

(D) The employee successfully completes a user seal check as described in paragraph (d)(2) of this section;

(E) The employee uses proper hand hygiene before putting the respirator on and conducting the user seal check; and

(F) The respirator has not been worn more than five days total.

Note to paragraph (d)(3)(i). The reuse of single-use respirators (e.g., filtering facepiece respirators) is discouraged.

(ii) The employer must ensure that an elastomeric respirator or PAPR is only reused when:

(A) The respirator is not damaged;

(B) The respirator is cleaned and disinfected as often as necessary to be maintained in a sanitary condition in accordance with § 1910.134, Appendix B-2; and

(C) A change schedule is implemented for cartridges, canisters, or filters.

(4) *Discontinuing use of respirators.* Employers must require employees to discontinue use of a respirator when either the employee or a supervisor reports medical signs or symptoms (e.g., shortness of breath, coughing, wheezing, chest pain, any other symptoms related to lung problems, cardiovascular symptoms) that are related to ability to use a respirator. Any employee who previously had a medical evaluation and was determined to not be medically fit to wear a respirator must not be provided with a respirator under this standard unless they are re-evaluated and medically cleared to use a respirator.

(e) *Effective date.* This section is effective as of June 21, 2021.

§ 1910.505 Severability.

Each section of this subpart U, and each provision within those sections, is separate and severable from the other sections and provisions. If any provision of this subpart is held to be invalid or unenforceable on its face, or as applied to any person, entity, or circumstance, or is stayed or enjoined, that provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event the provision shall be severable from this subpart and shall not affect the remainder of the subpart.

§ 1910.509 Incorporation by Reference.

(a)(1) The material listed in this section is incorporated by reference into this subpart with the approval of the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. To enforce any edition other than that specified in this section, OSHA must publish a document in the **Federal Register** and the material must

be available to the public. All approved material is available for inspection at any Regional Office of the Occupational Safety and Health Administration (OSHA), or at the OSHA Docket Office, U.S. Department of Labor, 200 Constitution Avenue NW, Room N-3508, Washington, DC 20210; telephone: 202-693-2350 (TTY number: 877-889-5627). It is also available for inspection at the National Archives and Records Administration (NARA). For information on the availability of these standards at NARA, email fedreg.legal@nara.gov, or go to www.archives.gov/federal-register/cfr/ibr-locations.html.

(2) The material is available from the sources listed in this section and as follows:

(i) The material listed in paragraphs (b) and (c) of this section (CDC and EPA) is available at this permanent weblink hosted by OSHA: www.osha.gov/coronavirus/ets/ibr.

(ii) The material listed in paragraph (d) of this section (ISEA) is available from the American National Standards Institute (ANSI), 25 West 43rd Street, 4th Floor, New York, NY 10036; telephone: 212-642-4900; fax: 212-398-0023; website: <http://www.ansi.org>.

(b) Centers for Disease Control and Prevention (CDC): 1600 Clifton Road, Atlanta, GA 30329; websites: <https://www.cdc.gov/>, <https://www.cdc.gov/coronavirus/2019-ncov/communication/guidance.html>, and <https://www.cdc.gov/infectioncontrol/guidelines/>.

(1) *Cleaning and Disinfecting Guidance.* COVID-19: Cleaning and Disinfecting Your Facility; Every Day and When Someone is Sick, updated April 5, 2021, IBR approved for § 1910.502(j).

(2) *COVID-19 Infection Prevention and Control Recommendations.* COVID-19: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated February 23, 2021, IBR approved for §§ 1910.502(d) and (j).

(3) *Guidelines for Isolation Precautions.* 2007 Guideline for

Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, updated July 2019, IBR approved for §§ 1910.502(e) and (f).

(4) *Guidelines for Environmental Infection Control.* Guidelines for Environmental Infection Control in Health-Care Facilities, updated July 2019, IBR approved for § 1910.502(j).

(5) *Isolation Guidance.* COVID-19: Isolation If You Are Sick; Separate yourself from others if you have COVID-19, updated February 18, 2021, IBR approved for § 1910.502(l).

(6) *Return to Work Healthcare Guidance.* COVID-19: Return to Work Criteria for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance), updated February 16, 2021, IBR approved for § 1910.502(l).

(c) U.S. Environmental Protection Agency (EPA): 1200 Pennsylvania Avenue NW, Washington, DC 20460; website: <https://www.epa.gov/>.

(1) List N. Pesticide Registration List N: Disinfectants for Coronavirus (COVID-19), updated April 9, 2021, IBR approved for § 1910.502(b).

(2) [Reserved]

(d) International Safety Equipment Association (ISEA): 1901 North Moore Street, Suite 808, Arlington, VA 22209; website: www.safetysiteequipment.org

(1) ANSI/ISEA Z87.1-2010, American National Standard for Occupational and Educational Personal Eye and Face Protection Devices, ANSI-approved April 13, 2010, IBR approved for § 1910.502(b).

(2) ANSI/ISEA Z87.1-2015, American National Standard for Occupational and Educational Personal Eye and Face Protection Devices, ANSI-approved May 28, 2015, IBR approved for § 1910.502(b).

(3) ANSI/ISEA Z87.1-2020, American National Standard for Occupational and Educational Personal Eye and Face Protection Devices, ANSI-approved March 11, 2020, IBR approved for § 1910.502(b).

[FR Doc. 2021-12428 Filed 6-17-21; 4:15 pm]
BILLING CODE 4510-26-P

DRAFT: JUNE 21, 2021

**VIRGINIA DEPARTMENT OF LABOR AND INDUSTRY (DOLI)
VIRGINIA OCCUPATIONAL SAFETY AND HEALTH (VOSH) PROGRAM**

SUBJECT: SIDE BY SIDE COMPARISON OF OSHA COVID-19 EMERGENCY TEMPORARY STANDARD (OSHA COVID-19 ETS), 1910.502, et seq, AND THE FINAL PERMANENT STANDARD (FPS) FOR INFECTIOUS DISEASE PREVENTION OF THE SARS-COV-2 VIRUS THAT CAUSES COVID-19, 16VAC25-220

The OSHA COVID-19 ETS and Preamble can be found at: <https://www.govinfo.gov/content/pkg/FR-2021-06-21/pdf/2021-12428.pdf>

NOTE: “ALAEA” means “at least as effective as,” OSH Act of 1970, 29 USC 667(c)(2), 655(c), Occupational Safety and Health Standards; 29 CFR 1953.5(b), Emergency temporary standards.

REFERENCES:

29 USC 667(c)(2) State Jurisdiction and State Plans

....

(c) The Secretary shall approve the plan submitted by a State under subsection (b), or any modification thereof, if such plan in his judgement --

(1) designates a State agency or agencies as the agency or agencies responsible for administering the plan throughout the State,

(2) provides for the development and enforcement of safety and health standards relating to one or more safety or health issues, **which standards (and the enforcement of which standards) are or will be at least as effective in providing safe and healthful employment and places of employment as the standards promulgated under section 6 which relate to the same issues**, and which standards, when applicable to products which are distributed or used in interstate commerce, are required by compelling local conditions and do not unduly burden interstate commerce....(Emphasis added).

29 USC 655(c) Occupational Safety and Health Standards.

....

(c) (1) The Secretary shall provide, without regard to the requirements of chapter 5, title 5, Unites States Code, for an emergency temporary standard to take immediate effect upon publication in the Federal Register if he determines --

(A) that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards, and

(B) that such emergency standard is necessary to protect employees from such danger.

(2) Such standard shall be effective until superseded by a standard promulgated in accordance with the procedures prescribed in paragraph (3) of this subsection.

(3) Upon publication of such standard in the Federal Register the Secretary shall commence a proceeding in accordance with section 6 (b) of this Act, and the standard as published shall also serve as a proposed rule for the proceeding. The Secretary shall promulgate a standard under this paragraph no later than six months after publication of the emergency standard as provided in paragraph (2) of this subsection.

(Emphasis added).

1953.5(b) Emergency temporary standards.

1953.5(b)(1) Immediately upon publication of an emergency temporary standard in the Federal Register, OSHA shall advise the States of the standard and that a Federal program change supplement shall be required. **This notification must also provide that the State has 30 days after the date of promulgation of the Federal standard to adopt a State emergency temporary standard if the State plan covers that issue. The State may demonstrate that promulgation of an emergency temporary standard is not necessary because the State standard is already the same as or at least as effective as the Federal standard change. The State standard must remain in effect for the duration of the Federal emergency temporary standard which may not exceed six (6) months.**

1953.5(b)(2) Within 15 days after receipt of the notice of a Federal emergency temporary standard, the State shall advise OSHA of the action it will take. State standards shall be submitted in accordance with the applicable procedures in § 1953.4(b) -- Federal Program Changes, except that the required documentation or plan supplement must be submitted within 5 days of State promulgation. (Emphasis added).

ETS Section	ETS Text	FPS Section	FPS Text	ALAEA Discussion Where Applicable	Comments
§1910.502(a) Scope and Application	<p>(a) Scope and application.</p> <p>(1) Except as otherwise provided in this paragraph, this section applies to all settings where any employee provides healthcare services or healthcare support services.</p> <p>(2) This section does not apply to the following:</p> <p>(i) the provision of first aid by an employee who is not a licensed healthcare provider;</p> <p>(ii) the dispensing of prescriptions by pharmacists in retail settings;</p> <p>(iii) non-hospital ambulatory care settings where all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings;</p> <p>(iv) well-defined hospital ambulatory care settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings;</p> <p>(v) home healthcare settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not present;</p> <p>(vi) healthcare support services not performed in a healthcare setting (e.g., off-site laundry, off-site medical billing); or</p> <p>(vii) telehealth services performed outside of a setting where direct patient care occurs.</p> <p>Note to paragraphs (a)(2)(iv) and (a)(2)(v): OSHA does not intend to preclude the employers of employees who are unable to be vaccinated from the scope exemption in paragraphs (a)(2)(iv) and (a)(2)(v). Under various anti-discrimination laws, workers who cannot be vaccinated because of medical conditions, such as allergies to vaccine ingredients, or certain religious beliefs may ask for a reasonable accommodation from their employer. Accordingly, where an employer reasonably accommodates an employee who is unable to be vaccinated in a manner that does not expose the employee to COVID-19 hazards (e.g., telework, working</p>	16VAC25-220-10. Purpose, scope, and applicability.	<p>Purpose, scope, and applicability.</p> <p>A. This standard is designed to establish requirements for employers to control, prevent, and mitigate the spread of SARS-CoV-2, the virus that causes coronavirus disease 2019 (COVID-19) to and among employees and employers.</p> <p>B. This standard is adopted in accordance with subdivision 6 a of § 40.1-22 of the Code of Virginia and shall apply to every employer, employee, and place of employment in the Commonwealth of Virginia within the jurisdiction of the VOSH program as described in 16VAC25- 60-20 and 16VAC25-60-30.</p> <p>C. This standard is designed to supplement and enhance existing VOSH laws, rules, regulations, and standards applicable directly or indirectly to SARS-CoV-2 virus or COVID-19 disease-related hazards such as, but not limited to, those dealing with personal protective equipment, respiratory protective equipment, sanitation, access to employee exposure and medical records, occupational exposure to hazardous chemicals in laboratories, hazard communication, § 40.1-51.1 A of the Code of Virginia, etc. Should this standard conflict with an existing VOSH rule, regulation, or standard, the more stringent requirement from an occupational safety and health hazard prevention standpoint shall apply. Notwithstanding anything to the contrary in this standard, no enforcement action shall be brought against an employer or institution for failure to provide PPE required by this standard if such PPE is not readily available on commercially reasonable terms and the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms. The Department of Labor and Industry shall consult with the Virginia Department of Health as to the ready availability of PPE on commercially reasonable terms and, in the event there are limited supplies of PPE, whether such supplies are being allocated to high risk or very high risk workplaces.</p> <p>D. Application of this standard to a place of employment will be based on the exposure risk level presented by SARS-CoV-2 virus-related and COVID-19 disease-related hazards present or job tasks undertaken by employees at the place of employment as defined in this standard (i.e., very high, high, medium, and lower risk levels).</p> <p>1. It is recognized that various hazards or job tasks at the same place of employment can be designated as very high, high, medium, or lower exposure risk for purposes of application of the requirements of</p>		<p>The OSHA ETS applies only to health care workers and even excludes some healthcare settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings.</p> <p>The FPS applies to “to every employer, employee, and place of employment in the Commonwealth of Virginia within the jurisdiction of the VOSH program as described in 16VAC25- 60-20 and 16VAC25-60-30.”</p>

<p>in isolation), that employer may be within the scope exemption in paragraphs (a)(2)(iv) and (a)(2)(v). (3) (i) Where a healthcare setting is embedded within a non-healthcare setting (e.g., medical clinic in a manufacturing facility, walk-in clinic in a retail setting), this section applies only to the embedded healthcare setting and not to the remainder of the physical location. (ii) Where emergency responders or other licensed healthcare providers enter a non-healthcare setting to provide healthcare services, this section applies only to the provision of the healthcare services by that employee. (4) In well-defined areas where there is no reasonable expectation that any person with suspected or confirmed COVID-19 will be present, paragraphs (f), (h), and (i) of this section do not apply to employees who are fully vaccinated. Note 1 to paragraph (a): Nothing in this section is intended to limit state or local government mandates or guidance (e.g., executive order, health department order) that go beyond the requirements of and are not inconsistent with this section.</p> <p>Note 2 to paragraph (a): Employers are encouraged to follow public health guidance from the Centers for Disease Control and Prevention (CDC) even when not required by this section.</p>		<p>this standard. It is further recognized that various required job tasks prohibit an employee from being able to observe physical distancing from other persons. 2. Factors that shall be considered in determining exposure risk level include, but are not limited to: a. The job tasks being undertaken, the work environment (e.g., indoors or outdoors), the known or suspected presence of the SARS-CoV-2 virus, the presence of a person known or suspected to be infected with the SARS-CoV-2 virus, the number of employees and other persons in relation to the size of the work area, the working distance between employees and other employees or persons, and the duration and frequency of employee exposure through contact inside of six feet with other employees or persons (e.g., including shift work exceeding eight hours per day); and b. The type of hazards encountered, including exposure to respiratory droplets and potential exposure to the airborne transmission of SARS-CoV-2 virus; contact with contaminated surfaces or objects, such as tools, workstations, or break room tables, and shared spaces such as shared workstations, break rooms, locker rooms, and entrances and exits to the facility; shared work vehicles; and industries or places of employment where employer sponsored shared transportation is a common practice, such as ride-share vans or shuttle vehicles, car-pools, and public transportation, etc.</p> <p>E. To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard. An employer's actual compliance with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 and COVID-19 related hazards or job tasks addressed by a provision of this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard. The Commissioner of Labor and Industry shall consult with the State Health Commissioner for advice and technical aid before making a determination related to compliance with CDC guidelines.</p> <p>F. A public or private institution of higher education that has received certification from the State Council of Higher Education for Virginia that the institution's reopening plans are in compliance with guidance documents, whether mandatory or non-mandatory, developed by the Governor's Office in conjunction with the Virginia Department of</p>		<p>[Yellow highlighted]</p> <p>Language is comparable.</p> <p>Some people contacting DOLI seem to be under a misunderstanding about the ability of the FPS to respond to changes in CDC guidance. 16VAC25-220-10.E directs the Commissioner of Labor and Industry shall consult with the State Health Commissioner for advice and technical aid before making a determination related to compliance with CDC guidelines.</p>
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			<p>Health shall be considered in compliance with this standard, provided the institution operates in compliance with its certified reopening plans and the certified reopening plans provide equivalent or greater levels of employee protection than this standard.</p> <p>G. A public school division or private school that submits its plans to the Virginia Department of Education to move to Phase II and Phase III that are aligned with CDC guidance for reopening of schools that provide equivalent or greater levels of employee protection than a provision of this standard and that operate in compliance with the public school division's or private school's submitted plans shall be considered in compliance with this standard. An institution's actual compliance with recommendations contained in CDC guidelines or the Virginia Department of Education guidance, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 and COVID19 related hazards or job tasks addressed by a provision of this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard. The Commissioner of Labor and Industry shall consult with the State Health Commissioner for advice and technical aid before making a determination related to compliance with CDC guidelines.</p> <p>H. Nothing in the standard shall be construed to require employers to conduct contact tracing of the SARS-CoV-2 virus or COVID-19 disease.</p>		<p>The Department has issued FAQs addressing the CDC's updates concerning persons who are fully vaccinated (see §10, FAQs 19-22, and §40, FAQs 46-54).</p> <p>https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/</p>
1910.502(b) Definitions	Aerosol-generating procedure means a medical procedure that generates aerosols that can be infectious and are of respirable size. For the purposes of this section, only the following medical procedures are considered aerosol-generating procedures: open suctioning of airways; sputum induction; cardiopulmonary resuscitation; endotracheal intubation and extubation; non-invasive ventilation (e.g., BiPAP, CPAP); bronchoscopy; manual ventilation; medical/surgical/postmortem procedures using oscillating bone saws; and dental procedures involving: ultrasonic scalers; high-speed dental handpieces; air/water syringes; air polishing; and air abrasion	16VAC25-220-30 Definitions	<p>[The following language is contained in the definition for "Exposure risk level," "very high"]</p> <p>1. Aerosol-generating procedures (e.g., intubation, cough induction procedures, bronchoscopies, some dental procedures and exams, or invasive specimen collection) on a patient or person known or suspected to be infected with the SARS-CoV-2 virus;</p>	Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (definition of "aerosol generating procedure")	The OSHA ETS definition is more detailed than the FPS in that it lists all the procedures that would be included. Some of which are not listed in the FPS.
	Airborne infection isolation room (AIIR) means a dedicated negative pressure patient-care room, with special air handling capability, which is used to isolate persons with a suspected or confirmed airborne-transmissible infectious disease. AIIRs include both permanent rooms and temporary structures (e.g., a booth,	16VAC25-220-30 Definitions	"Airborne infection isolation room" or "AIIR," formerly a negative pressure isolation room, means a single-occupancy patient-care room used to isolate persons with a suspected or confirmed airborne infectious disease. Environmental factors are controlled in AIIRs to minimize the transmission of infectious agents that are usually transmitted from person to person by droplet nuclei associated with coughing or aerosolization of contaminated fluids. AIIRs provide		Definitions are comparable

	tent or other enclosure designed to operate under negative pressure).		(i) negative pressure in the room so that air flows under the door gap into the room, (ii) an air flow rate of six to 12 air changes per hour (ACH) (six ACH for existing structures, 12 ACH for new construction or renovation), and (iii) direct exhaust of air from the room to the outside of the building or recirculation of air through a high efficiency particulate air (HEPA) filter before returning to circulation.		
	Ambulatory care means healthcare services performed on an outpatient basis, without admission to a hospital or other facility. It is provided in settings such as: offices of physicians and other health care professionals; hospital outpatient departments; ambulatory surgical centers; specialty clinics or centers (e.g., dialysis, infusion, medical imaging); and urgent care clinics. Ambulatory care does not include home healthcare settings for the purposes of this section.	16VAC25-220-30 Definitions	<p>"Exposure risk level" means the level of possibility that an employee could be exposed to the hazards associated with SARS-CoV-2 virus and the COVID-19 disease. The exposure risk level assessment should address all risks and all modes of transmission, including airborne transmission, as well as transmission by asymptomatic and presymptomatic individuals. Risk levels should be based on the risk factors present that increase risk exposure to COVID-19 and are present during the course of employment regardless of location. Hazards and job tasks have been divided into four risk exposure levels: very high, high, medium, and lower:</p> <p>"Very high" exposure risk hazards or job tasks are those in places of employment with high potential for employee exposure to known or suspected sources of the SARS-CoV-2 virus (e.g., laboratory samples) or persons known or suspected to be infected with the SARS-CoV-2 virus, including, but not limited to, during specific medical, postmortem, or laboratory procedures:</p> <ol style="list-style-type: none"> 1. Aerosol-generating procedures (e.g., intubation, cough induction procedures, bronchoscopies, some dental procedures and exams, or invasive specimen collection) on a patient or person known or suspected to be infected with the SARS-CoV-2 virus; 2. Collecting or handling specimens from a patient or person known or suspected to be infected with the SARS-CoV-2 virus (e.g., manipulating cultures from patients known or suspected to be infected with the SARS-CoV-2 virus); and 3. Performing an autopsy that involves aerosol-generating procedures on the body of a person known or suspected to be infected with the SARS-CoV-2 virus at the time of their death. <p>"High" exposure risk hazards or job tasks are those in places of employment with high potential for employee exposure inside six feet with known or suspected sources of SARSCoV-2, or with persons known or suspected to be infected with the SARS-CoV-2 virus that are not otherwise classified as very high exposure risk, including, but not limited to:</p>		There is no definition for "ambulatory care" in FPS. While the FPS does not use the same definition, it describes situations similar to the ambulatory care setting in the description for high exposure risk and medium exposure risk. However the OSHA ETS excludes home health care settings while the FPS includes it.

		<p>1. Health care (physical and mental health) delivery and support services provided to a patient known or suspected to be infected with the SARS-CoV-2 virus, including field hospitals (e.g., doctors, nurses, cleaners, and other hospital staff who must enter patient rooms or areas);</p> <p>2. Health care (physical and mental) delivery, care, and support services, wellness services, non-medical support services, physical assistance, etc., provided to a patient, resident, or other person known or suspected to be infected with the SARS-CoV-2 virus involving skilled nursing services, outpatient medical services, clinical services, drug treatment programs, medical outreach services, mental health services, home health care, nursing home care, assisted living care, memory care support and services, hospice care, rehabilitation services, primary and specialty medical care, dental care, COVID-19 testing services, blood donation services, and chiropractic services;</p> <p>3. First responder services provided to a patient, resident, or other person known or suspected to be infected with the SARS-CoV-2 virus;</p> <p>4. Medical transport services (loading, transporting, unloading, etc.) provided to patients known or suspected to be infected with the SARS-CoV-2 virus (e.g., ground or air emergency transport, staff, operators, drivers, pilots, etc.);</p> <p>5. Mortuary services involved in preparing (e.g., for burial or cremation) the bodies of persons who are known or suspected to be infected with the SARS-CoV-2 virus at the time of their death...</p> <p>"Medium" exposure risk hazards or job tasks are those not otherwise classified as very high or high exposure risk in places of employment that require more than minimal occupational contact inside six feet with other employees, other persons, or the general public who may be infected with SARS-CoV-2, but who are not known or suspected to be infected with the SARS-CoV-2 virus. Medium exposure risk hazards or job tasks may include, but are not limited to, operations and services in:</p> <p>....</p> <p>2. Situations not involving exposure to known or suspected sources of SARS-CoV-2:</p> <p>hospitals, other health care (physical and mental) delivery and support services in a nonhospital setting, wellness services, physical assistance, etc.; skilled nursing facilities; outpatient medical facilities; clinics, drug treatment programs, and medical outreach services; non-medical support services; mental health facilities; home health care, nursing homes, assisted living facilities, memory care facilities, and</p>		
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			hospice care; rehabilitation centers, doctors' offices, dentists' offices, and chiropractors' offices; first responders services provided by police, fire, paramedic and emergency medical services providers, medical transport; contact tracers; correctional facilities, jails, detentions centers, and juvenile detention centers, etc.		
	Assistant Secretary means the Assistant Secretary of Labor for Occupational Safety and Health, U.S. Department of Labor, or designee.		No comparable definition in the FPS.		Not applicable
	Clean/cleaning means the removal of dirt and impurities, including germs, from surfaces using soap and water or other cleaning agents. Cleaning alone reduces germs on surfaces by removing contaminants and may also weaken or damage some of the virus particles, which decreases risk of infection from surfaces.	16VAC25-220-30. Definitions.	"Cleaning" means the removal of dirt and impurities, including germs, from surfaces. Cleaning alone does not kill germs. But by removing the germs, cleaning decreases their number and therefore the risk of spreading infection.		Definitions are comparable See DOLI §40, FAQs 41, 42, 43 and 44 on CDC updates concerning cleaning and disinfecting. https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/
	Close contact means being within 6 feet of any other person for a cumulative total of 15 minutes or more over a 24-hour period during that person's potential period of transmission. The potential transmission period runs from 2 days before the person felt sick (or, for asymptomatic people, 2 days prior to test specimen collection) until the time the person is isolated.	16VAC25-220-30. Definitions.	No comparable definition in the FPS. The FPS contains a number of definitions where maintaining 6 feet of physical distancing is addressed: "Minimal occupational contact" means no or very limited, brief, and infrequent contact with employees or other persons at the place of employment. Examples include, but are not limited to, remote work (i.e., those working from home); employees with no more than brief contact with others inside six feet (e.g., passing another person in a hallway that does not allow physical distancing of six feet); health care employees providing only telemedicine services; a long distance truck driver. "Duration and frequency of employee exposure" means how long ("duration")....An example of a chronic situation could involve a job task that requires an employee to interact either for an extended period of time inside six feet with a smaller static group of other employees or persons or for an extended period of time inside six feet with a larger group of other employees or persons in succession but for periods of shorter duration.	Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (definition of "close contact")	The term "close contact" is intentionally not used in the FPS because it is used by the CDC for determining when contact tracing should be conducted and is defined as "any individual within 6 feet of an infected person for at least 15 minutes." It was the intention of DOLI and the Board to not place the burden of conducting contact tracing on employers. VDH conducts contact tracing. 16VAC25-220-10.H specifically provides that:

			<p>"High" exposure risk hazards or job tasks are those in places of employment with high potential for employee exposure inside six feet with known or suspected sources of SARSCoV-2, or with persons known or suspected to be infected with the SARS-CoV-2 virus that are not otherwise classified as very high exposure risk...</p> <p>"Medium" exposure risk hazards or job tasks are those not otherwise classified as very high or high exposure risk in places of employment that require more than minimal occupational contact inside six feet with other employees, other persons, or the general public who may be infected with SARS-CoV-2, but who are not known or suspected to be infected with the SARS-CoV-2 virus</p> <p>"Lower" exposure risk hazards or job tasks are those not otherwise classified as very high, high, or medium exposure risk that do not require contact inside six feet with persons known to be, or suspected of being, or who may be infected with SARS-CoV-2</p> <p>"Physical distancing" also called "social distancing" means a person keeping space between himself and other persons while conducting work-related activities inside and outside of the physical establishment by staying at least six feet from other persons.</p>		1. Nothing in the standard shall be construed to require employers to conduct contact tracing of the SARS-CoV-2 virus or COVID-19 disease.
	Common areas means indoor or outdoor locations under the control of the employer that more than one person may use or where people congregate (e.g., building lobbies, reception areas, waiting rooms, restrooms, break rooms, eating areas, conference rooms).	16VAC25-220-40(E) Mandatory requirements for all employers.	<p>No comparable definition in the FPS; however, see 16VAC25-220-40(E):</p> <p>E. Access to common areas, breakrooms, or lunchrooms shall be closed or controlled. If the nature of an employer's work or the work area does not allow employees to consume meals in the employee's workspace while observing physical distancing, an employer may designate, reconfigure, and alternate usage of spaces where employees congregate, including lunch and break rooms, locker rooms, time clocks, etc., with controlled access, provided the following conditions are met:</p>	Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (definition of "common areas")	
	COVID-19 (Coronavirus Disease 2019) means the respiratory disease caused by SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2). For clarity and ease of reference, this section refers to "COVID-19" when describing exposures or potential exposures to SARS-CoV-2	16VAC25-220-30. Definitions.	"COVID-19" means Coronavirus Disease 2019, which is primarily a respiratory disease, caused by the SARS-CoV-2 virus.		Definitions are comparable
	COVID-19 positive and confirmed COVID-19 refer to a person who has a confirmed positive test for, or who has	16VAC25-220-30. Definitions	"Known to be infected with the SARS-CoV-2 virus" means a person, whether symptomatic or asymptomatic, who has tested positive for SARS-CoV-2, and the employer knew or with reasonable diligence		Definitions are comparable

	been diagnosed by a licensed healthcare provider with, COVID-19.		<p>should have known that the person has tested positive for SARS-CoV-2.</p> <p>"Symptomatic" means a person is experiencing signs or symptoms attributed to COVID-19. A person may become symptomatic two to 14 days after exposure to the SARS-CoV-2 virus.</p>		
	COVID-19 symptoms mean the following: fever or chills; cough; shortness of breath or difficulty breathing; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea	16VAC25-220-30. Definitions	<p>"Signs of COVID-19" are medical conditions that can be objectively observed and may include fever, trouble breathing or shortness of breath, cough, vomiting, new confusion, bluish lips or face, etc.</p> <p>"Symptoms of COVID-19" are medical conditions that are subjective to the person and not observable to others and may include chills, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, congestion or runny nose, or diarrhea, etc.</p> <p>"Symptomatic" means a person is experiencing signs or symptoms attributed to COVID-19. A person may become symptomatic two to 14 days after exposure to the SARS-CoV-2 virus.</p>		Definitions are comparable
	COVID-19 test means a test for SARS-CoV-2 that is: (i) Cleared or approved by the U.S. Food and Drug Administration (FDA) or is authorized by an Emergency Use Authorization (EUA) from the FDA to diagnose current infection with the SARS-CoV-2 virus; and (ii) Administered in accordance with the FDA clearance or approval or the FDA EUA as applicable	16VAC25-220-40.B.3. Mandatory requirements for all employers.	<p>No comparable definition in FPS.</p> <p>The FPS does address the issue of serological testing:</p> <p>16VAC25-220-40.B.3 Serological testing, also known as antibody testing, is a test to determine if persons have been infected with SARS-CoV-2 virus. It has not been determined that persons who test positive for the presence of antibodies by serological testing are immune from infection.</p>	Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (definition of COVID-19 test)	
	Direct patient care means hands-on, face-to-face contact with patients for the purpose of diagnosis, treatment, and monitoring.		<p>No comparable definition in FPS.</p> <p>However, the FPS addresses the issue of patient care in several definitions:</p> <p>"High" exposure risk hazards or job tasks are those in places of employment with high potential for employee exposure inside six feet with known or suspected sources of SARSCoV-2, or with persons known or suspected to be infected with the SARS-CoV-2 virus that are not otherwise classified as very high exposure risk, including, but not limited to:</p> <p>1. Health care (physical and mental health) delivery and support services provided to a patient known or suspected to be infected</p>		Language is comparable

			<p>with the SARS-CoV-2 virus, including field hospitals (e.g., doctors, nurses, cleaners, and other hospital staff who must enter patient rooms or areas)....</p> <p>"Medium" exposure risk hazards or job tasks are those not otherwise classified as very high or high exposure risk in places of employment that require more than minimal occupational contact inside six feet with other employees, other persons, or the general public who may be infected with SARS-CoV-2, but who are not known or suspected to be infected with the SARS-CoV-2 virus. Medium exposure risk hazards or job tasks may include, but are not limited to, operations and services in:</p> <p>....</p> <p>2. Situations not involving exposure to known or suspected sources of SARS-CoV-2: hospitals, other health care (physical and mental) delivery and support services in a nonhospital setting, wellness services, physical assistance, etc.; skilled nursing facilities; outpatient medical facilities; clinics, drug treatment programs, and medical outreach services; non-medical support services; mental health facilities; home health care, nursing homes, assisted living facilities, memory care facilities, and hospice care; rehabilitation centers, doctors' offices, dentists' offices, and chiropractors' offices; first responders services provided by police, fire, paramedic and emergency medical services providers, medical transport; contact tracers; correctional facilities, jails, detentions centers, and juvenile detention centers, etc.</p>		
	<p>Disinfect/disinfection means using an EPA-registered, hospital-grade disinfectant on EPA's "List N" (incorporated by reference, § 1910.509), in accordance with manufacturers' instructions to kill germs on surfaces.</p>	<p>16VAC25-220-30. Definitions</p> <p>16VAC25-220-40.L.7. Mandatory requirements for all employers.</p>	<p>"Disinfecting" means using chemicals approved for use against SARS-CoV-2 virus, for example EPA-registered disinfectants, or non-EPA-registered disinfectants that otherwise meet the EPA criteria for use against SARS-CoV-2 virus, to kill germs on surfaces. The process of disinfecting does not necessarily clean dirty surfaces or remove germs, but killing germs remaining on a surface after cleaning further reduces any risk of spreading infection.</p> <p>L. Sanitation and disinfecting.</p> <p>....</p> <p>7. Employers shall ensure that cleaning and disinfecting products are readily available to employees to accomplish the required cleaning and disinfecting. In addition, employers shall ensure use of only disinfecting chemicals and products indicated in the Environmental Protection Agency (EPA) List N for use against SARS-CoV-2, or non-EPA registered disinfectants that otherwise meet the EPA criteria for use against SARS-CoV-2</p>		<p>Definitions are comparable</p>

	<p>Elastomeric respirator means a tight-fitting respirator with a facepiece that is made of synthetic or rubber material that permits it to be disinfected, cleaned, and reused according to manufacturer’s instructions. It is equipped with a replaceable cartridge(s), canister(s), or filter(s).</p>		<p>No comparable definition in FPS.</p> <p>However:</p> <p>"Respirator" means a protective device that covers the nose and mouth or the entire face or head to guard the wearer against hazardous atmospheres. Respirators are certified for use by the National Institute for Occupational Safety and Health (NIOSH). Respirators may be (i) tightfitting, which means either a half mask that covers the mouth and nose or a full face piece that covers the face from the hairline to below the chin or (ii) loose-fitting, such as hoods or helmets that cover the head completely. There are two major classes of respirators: 1. Air-purifying, which remove contaminants from the air; and 2. Atmosphere-supplying, which provide clean, breathable air from an uncontaminated source. As a general rule, atmosphere-supplying respirators are used for more hazardous exposures.</p>	<p>Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (definition of “elastomeric respirator”)</p>	
	<p>Facemask means a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as “medical procedure masks.”</p>		<p>"Surgical/medical procedure mask" means a mask to be worn over the wearer's nose and mouth that is fluid resistant and provides the wearer protection against large droplets, splashes, or sprays of bodily or other hazardous fluids, and prevents the wearer from exposing others in the same fashion. A surgical/medical procedure mask protects others from the wearer's respiratory emissions. A surgical/medical procedure mask has a looser fitting face seal than a tight-fitting respirator. A surgical/medical procedure mask does not provide the wearer with a reliable level of protection from inhaling smaller airborne particles. A surgical/medical procedure mask is considered a form of personal protective equipment, but is not considered respiratory protection equipment under VOSH laws, rules, regulations, and standards. Testing and approval is cleared by the U.S. Food and Drug Administration (FDA).</p>		<p>Definitions are comparable</p>
	<p>Face shield means a device, typically made of clear plastic, that: (i) is certified to ANSI/ISEA Z87.1 (incorporated by reference, § 1910.509); or (ii) covers the wearer’s eyes, nose, and mouth to protect from splashes, sprays, and spatter of body fluids, wraps around the sides of the wearer’s face (i.e., temple-to-temple), and extends below the wearer’s chin</p>		<p>"Face shield" means a form of personal protective equipment made of transparent, impermeable materials primarily used for eye protection from droplets or splashes for the person wearing it. A face shield is not a substitute for a face covering, surgical/medical procedure mask, or respirator.</p>		<p>Definitions are comparable</p>
	<p>Filtering facepiece respirator means a negative pressure particulate respirator with a non-replaceable filter as an integral part of the facepiece or with the entire facepiece composed of the non-replaceable filtering medium.</p>		<p>"Filtering facepiece respirator" means a negative pressure air purifying particulate respirator with a filter as an integral part of the facepiece or with the entire facepiece composed of the filtering</p>		<p>Definitions are comparable</p>

			medium. Filtering facepiece respirators are certified for use by the National Institute for Occupational Safety and Health (NIOSH).		
	Fully vaccinated means 2 weeks or more following the final dose of a COVID-19 vaccine.		No comparable definition in FPS.		<p>FPS does not mention Fully vaccinated, Vaccination, or vaccine.</p> <p>However, the Department has issued FAQs under 16VAC25-220-10.E addressing the CDC's updates concerning persons who are fully vaccinated (see §10, FAQs 19-22, and §40, FAQs 46-54).</p> <p>The FAQs can be found at: https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/</p>
	Hand hygiene means the cleaning and/or disinfecting of one's hands by using standard handwashing methods with soap and running water or an alcohol-based hand rub that is at least 60% alcohol.	<p>16VAC25-220-30. Definitions</p> <p>16VAC25-220-40.E.4. Mandatory requirements for all employers.</p> <p>16VAC25-220-40.L.9. Mandatory requirements for all employers.</p>	<p>No comparable definition in FPS.</p> <p>"Hand sanitizer" means an alcohol-based hand rub containing at least 60% alcohol, unless otherwise provided for in this standard.</p> <p>Hand sanitizer and handwashing facilities are addressed in a number of sections in the FPS:</p> <p>4. Handwashing facilities, and hand sanitizer where feasible, are available to employees. Hand sanitizers required for use to protect against SARS-CoV-2 are flammable and use and storage in hot environments can result in a hazard.</p> <p>9. Employees shall have easy, frequent access and permission to use soap and water, and hand sanitizer where feasible, for the duration of work. Employees assigned to a work station where job tasks require frequent interaction inside six feet with other persons shall be provided with hand sanitizer where feasible at the employees work station. 10. Mobile crews shall be provided with hand sanitizer where</p>		Language is comparable.

		<p>16VAC25-220-70.C.5(a). Infectious disease preparedness and response plan.</p>	<p>feasible for the duration of work at a work site or client or customer location and shall have transportation immediately available to nearby toilet facilities and handwashing facilities that meet the requirements of VOSH laws, standards, and regulations dealing with sanitation. Hand sanitizers required for use to protect against SARS-CoV-2 are flammable, and use and storage in hot environments can result in a hazard.</p> <p>5(a) Promote frequent and thorough hand washing, including by providing employees, customers, visitors, the general public, and other persons to the place of employment with a place to wash their hands. If soap and running water are not immediately available, provide hand sanitizers.</p>		
	<p>Healthcare services mean services that are provided to individuals by professional healthcare practitioners (e.g., doctors, nurses, emergency medical personnel, oral health professionals) for the purpose of promoting, maintaining, monitoring, or restoring health. Healthcare services are delivered through various means including: hospitalization, longterm care, ambulatory care, home health and hospice care, emergency medical response, and patient transport. For the purposes of this section, healthcare services include autopsies.</p>		<p>No comparable definition in FPS.</p> <p>However, the issue of healthcare services is addressed in the following definitions:</p> <p>"Very high" exposure risk hazards or job tasks are those in places of employment with high potential for employee exposure to known or suspected sources of the SARS-CoV-2 virus (e.g., laboratory samples) or persons known or suspected to be infected with the SARS-CoV-2 virus, including, but not limited to, during specific medical, postmortem, or laboratory procedures:</p> <ol style="list-style-type: none"> 1. Aerosol-generating procedures (e.g., intubation, cough induction procedures, bronchoscopies, some dental procedures and exams, or invasive specimen collection) on a patient or person known or suspected to be infected with the SARS-CoV-2 virus; 2. Collecting or handling specimens from a patient or person known or suspected to be infected with the SARS-CoV-2 virus (e.g., manipulating cultures from patients known or suspected to be infected with the SARS-CoV-2 virus); and 3. Performing an autopsy that involves aerosol-generating procedures on the body of a person known or suspected to be infected with the SARS-CoV-2 virus at the time of their death. <p>"High" exposure risk hazards or job tasks are those in places of employment with high potential for employee exposure inside six feet with known or suspected sources of SARSCoV-2, or with persons known or suspected to be infected with the SARS-CoV-2 virus that are not otherwise classified as very high exposure risk, including, but not limited to:</p>	<p>Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (definition of "healthcare services")</p>	

		<p>1. Health care (physical and mental health) delivery and support services provided to a patient known or suspected to be infected with the SARS-CoV-2 virus, including field hospitals (e.g., doctors, nurses, cleaners, and other hospital staff who must enter patient rooms or areas);</p> <p>2. Health care (physical and mental) delivery, care, and support services, wellness services, non-medical support services, physical assistance, etc., provided to a patient, resident, or other person known or suspected to be infected with the SARS-CoV-2 virus involving skilled nursing services, outpatient medical services, clinical services, drug treatment programs, medical outreach services, mental health services, home health care, nursing home care, assisted living care, memory care support and services, hospice care, rehabilitation services, primary and specialty medical care, dental care, COVID-19 testing services, blood donation services, and chiropractic services;</p> <p>3. First responder services provided to a patient, resident, or other person known or suspected to be infected with the SARS-CoV-2 virus;</p> <p>4. Medical transport services (loading, transporting, unloading, etc.) provided to patients known or suspected to be infected with the SARS-CoV-2 virus (e.g., ground or air emergency transport, staff, operators, drivers, pilots, etc.);</p> <p>5. Mortuary services involved in preparing (e.g., for burial or cremation) the bodies of persons who are known or suspected to be infected with the SARS-CoV-2 virus at the time of their death; and</p> <p>"Medium" exposure risk hazards or job tasks are those not otherwise classified as very high or high exposure risk in places of employment that require more than minimal occupational contact inside six feet with other employees, other persons, or the general public who may be infected with SARS-CoV-2, but who are not known or suspected to be infected with the SARS-CoV-2 virus. Medium exposure risk hazards or job tasks may include, but are not limited to, operations and services in:</p> <p>....</p> <p>2. Situations not involving exposure to known or suspected sources of SARS-CoV-2:</p> <p>hospitals, other health care (physical and mental) delivery and support services in a nonhospital setting, wellness services, physical assistance, etc.; skilled nursing facilities; outpatient medical facilities; clinics, drug treatment programs, and medical</p>		
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			outreach services; non-medical support services; mental health facilities; home health care, nursing homes, assisted living facilities, memory care facilities, and hospice care; rehabilitation centers, doctors' offices, dentists' offices, and chiropractors' offices; first responders services provided by police, fire, paramedic and emergency medical services providers, medical transport; contact tracers; correctional facilities, jails, detentions centers, and juvenile detention centers, etc.		
	Healthcare support services mean services that facilitate the provision of healthcare services. Healthcare support services include patient intake/admission, patient food services, equipment and facility maintenance, housekeeping services, healthcare laundry services, medical waste handling services, and medical equipment cleaning/reprocessing services.		No comparable definition in FPS. See response to OSHA ETS definition of “healthcare services” above.	Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (definition of “healthcare support services”)	
	High-touch surfaces and equipment means any surface or piece of equipment that is repeatedly touched by more than one person (e.g., doorknobs, light switches, countertops, handles, desks, tables, phones, keyboards, tools, toilets, faucets, sinks, credit card terminals, touchscreen-enabled devices).	16VAC25-220-40.L.4, 5, 6 Mandatory requirements for all employers.	No comparable definition in FPS. However, the FPS addresses the issue of cleaning/disinfecting certain types of surfaces: 4. Areas in the place of employment where employees or other persons known or suspected to be infected with the SARS-CoV-2 virus accessed or worked shall be cleaned and disinfected prior to allowing other employees access to the areas. Where feasible, a period of 24 hours will be observed prior to cleaning and disinfecting. This requirement shall not apply if the areas in question have been unoccupied for seven or more days. 5. All common spaces, including bathrooms (including port-a-johns, privies, etc.), frequently touched surfaces, and doors, shall at a minimum be cleaned and disinfected at least once during or at the end of the shift. Where multiple shifts are employed, such spaces shall be cleaned and disinfected no less than once every 12 hours. 6. All shared tools, equipment, workspaces, and vehicles shall be cleaned and disinfected prior to transfer from one employee to another.	Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (definition of “high-touch surfaces and equipment”)	See DOLI §40, FAQs 41, 42, 43 and 44 on CDC updates concerning cleaning and disinfecting. https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/
	Physical location means a site (including outdoor and indoor areas, a structure, or a group of structures) or an area within a site where work or any work-related activity		No comparable definition in FPS.	Possible ALAEA issue when comparing requirements in the OSHA	

	(e.g., taking breaks, going to the restroom, eating, entering, or exiting work) occurs. A physical location includes the entirety of any space associated with the site (e.g., workstations, hallways, stairwells, breakrooms, bathrooms, elevators) and any other space that an employee might occupy in arriving, working, or leaving		The FPS uses the terms “place of employment” and “workplace” but does not define them in detail	ETS to requirements in the FPS applicable to the healthcare industry (definition of “physical location”)	
	Powered air-purifying respirator (PAPR) means an air-purifying respirator that uses a blower to force the ambient air through air-purifying elements to the inlet covering		No comparable definition in the FPS. However, the term is defined in 1910.134, Respiratory Protection Standard, which applies in Virginia: “Powered air-purifying respirator (PAPR) means an air-purifying respirator that uses a blower to force the ambient air through air-purifying elements to the inlet covering.” https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134		The term is defined in 1910.134, Respiratory Protection Standard, which applies in Virginia.
	Respirator means a type of personal protective equipment (PPE) that is certified by NIOSH under 42 CFR part 84 or is authorized under an EUA by the FDA. Respirators protect against airborne hazards by removing specific air contaminants from the ambient (surrounding) air or by supplying breathable air from a safe source. Common types of respirators include filtering facepiece respirators, elastomeric respirators, and PAPRs. Face coverings, facemasks, and face shields are not respirators.		"Respirator" means a protective device that covers the nose and mouth or the entire face or head to guard the wearer against hazardous atmospheres. Respirators are certified for use by the National Institute for Occupational Safety and Health (NIOSH). Respirators may be (i) tightfitting, which means either a half mask that covers the mouth and nose or a full face piece that covers the face from the hairline to below the chin or (ii) loose-fitting, such as hoods or helmets that cover the head completely. There are two major classes of respirators: 1. Air-purifying, which remove contaminants from the air; and 2. Atmosphere-supplying, which provide clean, breathable air from an uncontaminated source. As a general rule, atmosphere-supplying respirators are used for more hazardous exposures.		Definitions are comparable
	Screen means asking questions to determine whether a person is COVID-19 positive or has symptoms of COVID-19.	16VAC25-220-50.C.1 Requirements for hazards or job tasks classified as very high or high exposure risk.	No comparable definition in FPS. However, the FPS addresses the issue of screening: 50.C.1. Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19.		Language is comparable

		16VAC25-220-60.C1 Requirements for hazards or job tasks classified at medium exposure risk.	60.C.1. Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19.		
	Surgical mask means a mask that covers the user's nose and mouth and provides a physical barrier to fluids and particulate materials. The mask meets certain fluid barrier protection standards and Class I or Class II flammability tests. Surgical masks are generally regulated by FDA as Class II devices under 21 CFR 878.4040 – Surgical apparel.		"Surgical/medical procedure mask" means a mask to be worn over the wearer's nose and mouth that is fluid resistant and provides the wearer protection against large droplets, splashes, or sprays of bodily or other hazardous fluids, and prevents the wearer from exposing others in the same fashion. A surgical/medical procedure mask protects others from the wearer's respiratory emissions. A surgical/medical procedure mask has a looser fitting face seal than a tight-fitting respirator. A surgical/medical procedure mask does not provide the wearer with a reliable level of protection from inhaling smaller airborne particles. A surgical/medical procedure mask is considered a form of personal protective equipment, but is not considered respiratory protection equipment under VOSH laws, rules, regulations, and standards. Testing and approval is cleared by the U.S. Food and Drug Administration (FDA).		Definitions are comparable
	Vaccine means a biological product authorized or licensed by the FDA to prevent or provide protection against COVID-19, whether the substance is administered through a single dose or a series of doses.		No comparable definition in FPS.		FPS does not mention Fully vaccinated, Vaccination, or vaccine. However, the Department has issued FAQs under 16VAC25-220-10.E addressing the CDC's updates concerning persons who are fully vaccinated (see §10, FAQs 19-22, and §40, FAQs 46-54). The FAQs can be found at: https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/
	Workplace means a physical location (e.g., fixed, mobile) where the employer's work or operations are performed.		No comparable definition in FPS.		The term is addressed in Occupational Safety and

			The FPS uses the terms “place of employment” and “workplace” but does not define them in detail		Health Review Commission court decisions in sufficient detail.
§1910.502(c) COVID-19 Plan	<p>(c) COVID-19 plan.</p> <p>(1) The employer must develop and implement a COVID-19 plan for each workplace. If the employer has multiple workplaces that are substantially similar, its COVID-19 plan may be developed by workplace type rather than by individual workplace so long as all required site-specific information is included in the plan.</p> <p>(2) If the employer has more than 10 employees, the COVID-19 plan must be written.</p> <p>(3) The employer must designate one or more workplace COVID-19 safety coordinators to implement and monitor the COVID-19 plan developed under this section. The COVID-19 safety coordinator(s) must be knowledgeable in infection control principles and practices as they apply to the workplace and employee job operations. The identity of the safety coordinator(s) must be documented in any written COVID-19 plan. The safety coordinator(s) must have the authority to ensure compliance with all aspects of the COVID-19 plan.</p> <p>(4) (i) The employer must conduct a workplace-specific hazard assessment to identify potential workplace hazards related to COVID-19. (ii) In order for an employer to be exempt from providing controls in a well-defined area under paragraph (a)(4) of this section based on employees’ fully vaccinated status, the COVID-19 plan must include policies and procedures to determine employees’ vaccination status.</p> <p>(5) The employer must seek the input and involvement of non-managerial employees and their representatives, if any, in the hazard assessment and the development and implementation of the COVID-19 plan.</p> <p>(6) The employer must monitor each workplace to ensure the ongoing effectiveness of the COVID-19 plan and update it as needed.</p> <p>(7) The COVID-19 plan must address the hazards identified by the assessment required by paragraph (c)(4) of this section, and include policies and procedures to:</p> <p>(i) Minimize the risk of transmission of COVID-19 for each employee, as required by paragraphs (d) through (n) of this section; Note to paragraph (c)(7)(i): Although the</p>	16VAC25-220-70 Infectious disease preparedness and response plan.	<p>A. Employers with hazards or job tasks classified as:</p> <ol style="list-style-type: none"> 1. Very high and high shall develop and implement a written Infectious Disease Preparedness and Response Plan; 2. Medium with 11 or more employees shall develop and implement a written Infectious Disease Preparedness and Response Plan. <p>B. The plan and training requirements tied to the plan shall only apply to those employees classified as very high, high, and medium covered by this section.</p> <p>C. Employers shall designate a person to be responsible for implementing their plan.</p> <p>The plan shall:</p> <ol style="list-style-type: none"> 1. Identify the name or title of the person responsible for administering the plan. This person shall be knowledgeable in infection control principles and practices as the principles and practices apply to the facility, service, or operation. 2. Provide for employee involvement in development and implementation of the plan. 3. Consider and address the level of SARS-CoV-2 virus and COVID-19 disease risk associated with various places of employment, the hazards employees are exposed to at those sites, and job tasks employees perform at those sites. <p>Such considerations shall include:</p> <ol style="list-style-type: none"> a. Where, how, and to what sources of the SARS-CoV-2 virus or COVID-19 disease might employees be exposed at work, including: <ol style="list-style-type: none"> (1) The general public, customers, other employees, patients, and other persons; (2) Persons known or suspected to be infected with the SARS-CoV-2 virus or those at particularly high risk of COVID-19 infection (e.g., local, state, national, and international travelers who have visited locations with ongoing COVID-19 community transmission and health care employees who have had unprotected exposures to persons known or suspected to be infected with SARS-CoV-2 virus); (3) Situations where employees work more than one job with different employers and encounter hazards or engage in job tasks that present a very high, high, or medium level of exposure risk; and (4) Situations where employees work during higher risk activities involving potentially large numbers of people or enclosed work areas such as at large social gatherings, weddings, funerals, parties, restaurants, bars, hotels, sporting events, concerts, parades, movie 		Requirements are comparable.

<p>employer's COVID-19 plan must account for the potential COVID-19 exposures to each employee, the plan can do so generally and need not address each employee individually. (ii) Effectively communicate and coordinate with other employers: (A) When employees of different employers share the same physical location, each employer must effectively communicate its COVID-19 plan to all other employers, coordinate to ensure that each of its employees is protected as required by this section, and adjust its COVID-19 plan to address any particular COVID-19 hazards presented by the other employees. This requirement does not apply to delivery people, messengers, and other employees who only enter a workplace briefly to drop off or pick up items. (B) An employer with one or more employees working in a physical location controlled by another employer must notify the controlling employer when those employees are exposed to conditions at that location that do not meet the requirements of this section; and (iii) Protect employees who in the course of their employment enter into private residences or other physical locations controlled by a person not covered by the OSH Act (e.g., homeowners, sole proprietors). This must include procedures for employee withdrawal from that location if those protections are inadequate. Note to paragraph (c): The employer may include other policies, procedures, or information necessary to comply with any applicable federal, state, or local public health laws, standards, and guidelines in their COVID-19 plan.</p>		<p>theaters, rest stops, airports, bus stations, train stations, cruise ships, river boats, airplanes, etc.</p> <p>b. To the extent permitted by law, including HIPAA, employees' individual risk factors for severe disease. For example, people of any age with one or more of the following conditions are at increased risk of severe illness from COVID-19: chronic kidney disease; COPD (chronic obstructive pulmonary disease); immunocompromised state (weakened immune system) from solid organ transplant; obesity (body mass index or BMI of 30 or higher); serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies; sickle cell disease; or type 2 diabetes mellitus. Also, for example, people with one or more of the following conditions might be at an increased risk for severe illness from COVID-19: asthma (moderate-to-severe); cerebrovascular disease (affects blood vessels and blood supply to the brain); cystic fibrosis; hypertension or high blood pressure; immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines; neurologic conditions, such as dementia; liver disease; pregnancy; pulmonary fibrosis (having damaged or scarred lung tissues); smoking; thalassemia (a type of blood disorder); type 1 diabetes mellitus; etc. The risk for severe illness from COVID-19 also increases with age.</p> <p>c. Engineering, administrative, work practice, and personal protective equipment controls necessary to address those risks.</p> <p>4. Consider and address contingency plans for situations that may arise as a result of outbreaks that impact employee safety and health, such as:</p> <p>a. Increased rates of employee absenteeism (an understaffed business can be at greater risk for accidents);</p> <p>b. The need for physical distancing, staggered work shifts, downsizing operations, delivering services remotely, and other exposure-reducing workplace control measures such as elimination and substitution, engineering controls, administrative and work practice controls, and personal protective equipment (e.g., respirators, surgical/medical procedure masks, etc.); c. Options for conducting essential operations in a safe and healthy manner with a reduced workforce; and</p> <p>d. Interrupted supply chains or delayed deliveries of safety and health related products and services essential to business operations.</p> <p>5. Identify infection prevention measures to be implemented:</p> <p>a. Promote frequent and thorough hand washing, including by providing employees, customers, visitors, the general public, and other persons to the place of employment with a place to wash their</p>		
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			<p>hands. If soap and running water are not immediately available, provide hand sanitizers.</p> <p>b. Maintain regular housekeeping practices, including routine cleaning and disinfecting of surfaces, equipment, and other elements of the work environment. c. Establish policies and procedures for managing and educating visitors about the procedures at the place of employment.</p> <p>6. Provide for the prompt identification and isolation of employees known or suspected to be infected with the SARS-CoV-2 virus away from work, including procedures for employees to report when they are experiencing signs or symptoms of COVID-19.</p> <p>7. Address infectious disease preparedness and response with outside businesses, including, but not limited to, subcontractors who enter the place of employment, businesses that provide contract or temporary employees to the employer, and other persons accessing the place of employment to comply with the requirements of this standard and the employer's plan.</p> <p>8. Identify the mandatory and non-mandatory recommendations in any CDC guidelines or Commonwealth of Virginia guidance documents the employer is complying with, if any, in lieu of a provision of this standard, as provided for in 16VAC25-220-10 E, F, and G.</p>		
§1910.502(d)	<p>Patient screening and management.</p> <p>In settings where direct patient care is provided, the employer must:</p> <p>(1) Limit and monitor points of entry to the setting. This provision does not apply where emergency responders or other licensed healthcare providers enter a non-healthcare setting to provide healthcare services.</p> <p>(2) Screen and triage all clients, patients, residents, delivery people and other visitors, and other non-employees entering the setting.</p> <p>(3) Implement other applicable patient management strategies in accordance with CDC's "COVID-19 Infection Prevention and Control Recommendations" (incorporated by reference, § 1910.509).</p> <p>Note to paragraph (d): The employer is encouraged to use telehealth services where available and appropriate in order to limit the number of people entering the workplace.</p>	<p>16VAC25-220-50.C.1 Requirements for hazards or job tasks classified as very high or high exposure risk.</p> <p>16VAC25-220-60.C1 Requirements for hazards or job tasks classified at medium exposure risk.</p>	<p>No comparable requirement in FPS for "patient" screening.</p> <p>However, the FPS addresses the issue of employee screening:</p> <p>50.C.1. Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19.</p> <p>60.C.1. Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19.</p>	Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (patient screening and management requirements)	
§1910.502(e) Standard and Transmission-	(e) Standard and Transmission-Based Precautions. Employers must develop and implement policies and procedures to adhere to Standard and Transmission-	16VAC25-220-10.E	E. To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID19		Provisions are comparable.

Based Precautions.	Based Precautions in accordance with CDC’s “Guidelines for Isolation Precautions” (incorporated by reference, § 1910.509).	Purpose, scope, and applicability.	<p>disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard. An employer's actual compliance with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 and COVID-19 related hazards or job tasks addressed by a provision of this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard. The Commissioner of Labor and Industry shall consult with the State Health Commissioner for advice and technical aid before making a determination related to compliance with CDC guidelines.</p> <p>16VAC25-220-40. Mandatory requirements for all employers.</p> <p>A. Employers shall ensure compliance with the requirements in this section to protect employees in all exposure risk levels from workplace exposure to the SARS-CoV-2 virus that causes the COVID-19 disease.</p> <p>B. Exposure assessment and determination, notification requirements, and employee access to exposure and medical records.</p> <p>16VAC25-220-70. Infectious disease preparedness and response plan</p> <p>A. Employers with hazards or job tasks classified as:</p> <ol style="list-style-type: none"> 1. Very high and high shall develop and implement a written Infectious Disease Preparedness and Response Plan; 2. Medium with 11 or more employees shall develop and implement a written Infectious Disease Preparedness and Response Plan.... 		16VAC25-220-10.E of the FPS provides employers the flexibility to comply with CDC guidelines “whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard”
§1910.502(f) Personal Protective Equipment	(f) Personal protective equipment (PPE). (1) Facemasks. (i) Employers must provide, and ensure that employees wear, facemasks that meet the definition in paragraph (b) of this section; and (ii) The employer must ensure a facemask is worn by each employee over the nose and mouth when indoors and when occupying a vehicle with other people for work purposes. The employer must provide a sufficient number of facemasks to each employee to comply with this paragraph and must ensure that each employee changes them at least once per day, whenever they are soiled or damaged, and more frequently as necessary (e.g., patient care reasons).	16 VAC25-220-50.D. Requirements for hazards or jobs classified as very high or high exposure risk	D. Personal protective equipment (PPE). Employers covered by this section and not otherwise covered by the VOSH Standards for General Industry (16VAC25-90-1910.132), shall comply with the following requirements for a SARS-CoV-2 virus and COVID-19 disease-related hazard assessment and personal protective equipment selection: 1. Employers shall assess the workplace to determine if SARS-CoV-2 virus or COVID-19 disease hazards or job tasks are present or are likely to be present that necessitate the use of personal protective equipment (PPE). Employers shall provide for employee and employee representative involvement in the assessment process. If such hazards or job tasks are present or likely to be present, employers shall:	Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (e.g., see possible examples highlighted in yellow)	The OSHA ETS only covers health care workers and requires “facemasks” when providing healthcare services. Since the FPS covers all workers, the approach to PPE and face coverings is different in that the level of protection required will depend on the level of exposure to the hazard (very high, high, medium)

<p>(iii) The following are exceptions to the requirements for facemasks in paragraph (f)(1)(ii) of this section: (A) When an employee is alone in a room. (B) While an employee is eating and drinking at the workplace, provided each employee is at least 6 feet away from any other person, or separated from other people by a physical barrier. (C) When employees are wearing respiratory protection in accordance with § 1910.134 or paragraph (f) of this section. (D) When it is important to see a person’s mouth (e.g., communicating with an individual who is deaf or hard of hearing) and the conditions do not permit a facemask that is constructed of clear plastic (or includes a clear plastic window). In such situations, the employer must ensure that each employee wears an alternative to protect the employee, such as a face shield, if the conditions permit it.</p>		<p>On shared work vehicles: 16VAC25-220-40.F. Mandatory requirements for all employers.</p>	<p>a. Except as otherwise required in the standard, select and have each affected employee use the types of PPE that will protect the affected employee from the SARS-CoV-2 virus or COVID-19 disease hazards identified in the hazard assessment; b. Communicate selection decisions to each affected employee; and c. Select PPE that properly fits each affected employee. 2. Employers shall verify that the required SARS-CoV-2 virus and COVID-19 disease workplace hazard assessment has been performed through a written certification that identifies the workplace evaluated, the person certifying that the evaluation has been performed, the date of the hazard assessment, and the document as a certification of hazard assessment. 3. Unless specifically addressed by an industry specific standard applicable to the employer and providing for PPE protections to employees from the SARS-COV-2 virus or COVID-19 disease (e.g., 16VAC25-175-1926, 16VAC25-190-1928, 16VAC25-100-1915, 16VAC25-120-1917, or 16VAC25-130-1918), the requirements of 16VAC25-90-1910.132 (General requirements) and 16VAC25-90-1910.134 (Respiratory protection) shall apply to all employers for that purpose. 4. Unless contraindicated by a hazard assessment and equipment selection requirements in subdivision 1 of this subsection, employees classified as very high or high exposure risk shall be provided with and wear gloves, a gown, a face shield or goggles, and a respirator when in contact with or inside six feet of patients or other persons known to be or suspected of being infected with SARS-CoV-2. Gowns shall be the correct size to assure protection.</p> <p>F. When multiple employees are occupying a vehicle for work purposes, employers shall use the hierarchy of hazard controls to mitigate the hazards associated with SARS-CoV-2 and COVID19 to prevent employee exposures in the following order: 1. Eliminate the need for employees to share work vehicles and arrange for alternative means for additional employees to travel to work sites. 2. Provide access to fresh air ventilation (e.g., windows). Do not recirculate cabin air. 3. When physical distancing cannot be maintained, establish procedures to maximize separation between employees during travel (e.g., setting occupancy limits, sitting in alternate seats, etc.). 4. When employees must share work vehicles because no other alternatives are available, employees shall be provided with respiratory protection, such as an N95 filtering face piece respirator. The employer shall ensure compliance with respiratory protection and</p>	<p>and lower exposure risk), with the determination being made by the employer.</p> <p>In some industries where the risk is determined to be medium or lower, a “facemask” as defined by the OSHA ETS would not be required unless the employer determined so during their PPE hazard assessment.</p> <p>In evaluating those health care workers that the OSHA ETS does not exempt from the ETS under the FPS, those health care workers would likely fall into the “high risk” category and would need to comply with section 16VAC25-220-50.D of the FPS, requiring the employer to evaluate the level of PPE required.</p> <p>Section 50.D.4 requires employees must be provided and wear a respirator unless contraindicated by a hazard assessment when inside of 6 feet of patients or persons known to be or suspected to be infected with SARS-Co-V-2. The OSHA ETS requires the same in a note to section f.</p> <p>By performing the PPE assessment required by the</p>
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	<p>(E) When employees cannot wear facemasks due to a medical necessity, medical condition, or disability as defined in the Americans with Disabilities Act (42 USC 12101 et seq.), or due to a religious belief. Exceptions must be provided for a narrow subset of persons with a disability who cannot wear a facemask or cannot safely wear a facemask, because of the disability, as defined in the Americans with Disabilities Act (42 USC 12101 et seq.), including a person who cannot independently remove the facemask. The remaining portion of the subset who cannot wear a facemask may be exempted on a case-by-case basis as required by the Americans with Disabilities Act and other applicable laws. In all such situations, the employer must ensure that any such employee wears a face shield for the protection of the employee, if their condition or disability permits it. Accommodations may also need to be made for religious beliefs consistent with Title VII of the Civil Rights Act. (F) When the employer can demonstrate that the use of a facemask presents a hazard to an employee of serious injury or death (e.g., arc flash, heat stress, interfering with the safe operation of equipment). In such situations, the employer must ensure that each employee wears an alternative to protect the employee, such as a face shield, if the conditions permit it. Any employee not wearing a facemask must remain at least 6 feet away from all other people unless the</p>	<p>On exemptions from facemask (or in some cases “face coverings” under the FPS) for medical or religious reasons and use of face shield: 16VAC25-220.40.J. Mandatory requirements for all employers.</p>	<p>personal protective equipment standards applicable to the employer's industry.</p> <p>5. Until adequate supplies of respiratory protection and/or personal protective equipment become readily available for non-medical and non-first responder employers and employees, employers shall provide and employees shall wear face coverings while occupying a work vehicle with other employees or persons. Notwithstanding anything to the contrary in this standard, the Secretary of Commerce and Trade may exercise discretion in the enforcement of an employer's failure to provide PPE required by this standard, if the employer demonstrates that the employer:</p> <p>a. Is exercising due diligence to come into compliance with such requirement; and b. Is implementing alternative methods and measures to protect employees that are satisfactory to the Secretary of Commerce and Trade after consultation with the Commissioner and the Secretary of Health and Human Services.</p> <p>J. Nothing in this standard shall require the use of a respirator, surgical/medical procedure mask, or face covering by any employee for whom doing so would be contrary to the employee's health or safety because of a medical condition; however, nothing in this standard shall negate an employer's obligations to comply with personal protective equipment and respiratory protection standards applicable to its industry.</p> <p>1. Although face shields are not considered a substitute for face coverings as a method of source control and not used as a replacement for face coverings among people without medical contraindications, face shields may provide some level of protection against contact with respiratory droplets. In situations where a face covering cannot be worn due to medical contraindications, employers shall provide and employees shall wear either:</p> <p>a. A face shield that wraps around the sides of the wearer's face and extends below the chin; or</p> <p>b. A hooded face shield.</p> <p>2. To the extent feasible, employees wearing face shields in accordance with this subsection shall observe physical distancing requirements in this standard.</p> <p>3. Face shield wearers shall wash their hands before and after removing the face shield and avoid touching their eyes, nose, and mouth when removing it.</p> <p>4. Disposable face shields shall only be worn for a single use and disposed of according to manufacturer instructions.</p> <p>5. Reusable face shields shall be cleaned and disinfected after each use according to manufacturer instructions.</p>		<p>FPS, the healthcare workers covered by the OSHA ETS could be required to either wear a surgical/medical procedure mask (a “facemask” under the ETS) or in some cases a respirator—the FPS is as effective as the OSHA ETS in this regard.</p> <p>The OSHA ETS requires the use of a facemask while occupying a work vehicle with other people for work purposes. The FPS has a similar provision which uses the hierarchy of controls for multiple employees occupying a work vehicle for work purposes. If there are no alternatives to occupying a vehicle with multiple employees, the employees must wear a respirator which affords more protection than a facemask. The FPS is as effective as the ETS in this regard.</p>
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<p>employer can demonstrate it is not feasible. The employee must resume wearing a facemask when not engaged in the activity where the facemask presents a hazard.</p> <p>Note to paragraph (f)(1)(iii)(F): With respect to paragraphs (f)(1)(iii)(D) through (F) of this section, the employer may determine that the use of face shields, without facemasks, in certain settings is not appropriate due to other infection control concerns.</p> <p>(iv) Where a face shield is required to comply with this paragraph or is otherwise required by the employer, the employer must ensure that face shields are cleaned at least daily and are not damaged. When an employee provides a face shield that meets the definition in paragraph (b) of this section, the employer may allow the employee to use it and is not required to reimburse the employee for that face shield.</p> <p>(2) Respirators and other PPE for exposure to people with suspected or confirmed COVID-19. When employees have exposure to a person with suspected or confirmed COVID-19, the employer must provide:</p> <p>(i) a respirator to each employee and ensure that it is provided and used in accordance with § 1910.134 and</p> <p>(ii) gloves, an isolation gown or protective clothing, and eye protection to each employee and ensure that the PPE is used in accordance with subpart I of this part.</p> <p>Note to paragraph (f)(2): When there is a limited supply of filtering facepiece respirators, employers may follow the CDC’s “Strategies for Optimizing the Supply of N95 Respirators” (available at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html). Where possible, employers are encouraged to select elastomeric respirators or PAPRs instead of filtering facepiece respirators to prevent shortages and supply chain disruption.</p> <p>(3) Respirators and other PPE during aerosol-generating procedures. For aerosol-generating procedures performed on a person with suspected or confirmed COVID-19, the employer must provide:</p>		<p>4. Unless contraindicated by a hazard assessment and equipment selection requirements in subdivision 1 of this subsection, employees classified as very high or high exposure risk shall be provided with and wear gloves, a gown, a face shield or goggles, and a</p>		
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<p>(i) a respirator to each employee and ensure that it is provided and used in accordance with § 1910.134; and (ii) gloves, an isolation gown or protective clothing, and eye protection to each employee and ensure that the PPE is used in accordance with subpart I of this part.</p> <p>Note 1 to paragraph (f)(3): For aerosol-generating procedures on a person suspected or confirmed with COVID-19, employers are encouraged to select elastomeric respirators or PAPRs instead of filtering facepiece respirators.</p> <p>Note 2 to paragraph (f)(3): Additional requirements specific to aerosol-generating procedures on people with suspected or confirmed COVID-19 are contained in paragraph (g) of this section.</p> <p>(4) Use of respirators when not required. (i) The employer may provide a respirator to the employee instead of a facemask as required by paragraph (f)(1) of this section. In such circumstances, the employer must comply with § 1910.504. (ii) Where the employer provides the employee with a facemask as required by paragraph (f)(1) of this section, the employer must permit the employee to wear their own respirator instead of a facemask. In such circumstances, the employer must also comply with § 1910.504.</p> <p>(5) Respirators and other PPE based on Standard and Transmission-Based Precautions. The employer must provide protective clothing and equipment (e.g., respirators, gloves, gowns, goggles, face shields) to each employee in accordance with Standard and Transmission-Based Precautions in healthcare settings in accordance with CDC’s “Guidelines for Isolation Precautions” (incorporated by reference, § 1910.509) and ensure that the protective clothing and equipment is used in accordance with subpart I of this part.</p>	<p>16VAC25-220-50.D.4. Requirements for hazards or job tasks classified as very high or high exposure risk.</p> <p>16VAC25-220-90.B Discrimination against an employee for exercising rights under this standard is prohibited.</p> <p>16VAC25-220-10.E Purpose, scope, and applicability.</p>	<p>respirator when in contact with or inside six feet of patients or other persons known to be or suspected of being infected with SARS-CoV-2. Gowns shall be the correct size to assure protection.</p> <p>B. No person shall discharge or in any way discriminate against an employee who voluntarily provides and wears the employee's own personal protective equipment, including, but not limited to, a respirator, face shield, gown, or gloves, provided that the PPE does not create a greater hazard to the employee or create a serious hazard for other employees. In situations where face coverings are not provided by the employer, no person shall discharge or in any way discriminate against an employee who voluntarily provides and wears the employee's own face covering that meets the requirements of this standard, provided that the face covering does not create a greater hazard to the employee or create a serious hazard for other employees. Nothing in this subsection shall be construed to prohibit an employer from establishing and enforcing legally permissible dress code or similar requirements addressing the exterior appearance of personal protective equipment or face coverings.</p> <p>E. To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard. An employer's actual compliance with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 and COVID-19 related hazards or job tasks</p>			<p>16VAC25-220-10.E of the FPS provides employers the flexibility to comply with CDC guidelines “whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID19 disease related hazards or job tasks addressed by this</p>
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			addressed by a provision of this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard. The Commissioner of Labor and Industry shall consult with the State Health Commissioner for advice and technical aid before making a determination related to compliance with CDC guidelines.		standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard”
§1910.502(g) Aerosol-generating procedures on a person with suspected or confirmed COVID-19	When an aerosol-generating procedure is performed on a person with suspected or confirmed COVID-19: (1) The employer must limit the number of employees present during the procedure to only those essential for patient care and procedure support. (2) The employer must ensure that the procedure is performed in an existing AIIR, if available. (3) After the procedure is completed, the employer must clean and disinfect the surfaces and equipment in the room or area where the procedure was performed. Note to paragraph (g): Respirators and other PPE requirements during aerosol-generating procedures are contained in paragraph (f)(3) of this section.	16VAC25-220-50.B.3, 4 and 5 Requirements for hazards or job task classified as very high or high exposure risk: Engineering controls 16VAC25-220-40.L.4 Mandatory requirements for all employers	B.3. Hospitalized patients known or suspected to be infected with the SARS-CoV-2 virus, where feasible and available, shall be placed in airborne infection isolation room (AIIRs). B.4. Employers shall use AIIRs when available for performing aerosol-generating procedures on patients with known or suspected to be infected with the SARS-CoV-2 virus. B.5. For postmortem activities, employers shall use autopsy suites or other similar isolation facilities when performing aerosol-generating procedures on the bodies of persons known or suspected to be infected with the SARS-CoV-2 virus at the time of their death. L.4. Areas in the place of employment where employees or other persons known or suspected to be infected with the SARS-CoV-2 virus accessed or worked shall be cleaned and disinfected prior to allowing other employees access to the areas.	[Language highlighted in yellow] Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (The employer must limit the number of employees present during the procedure to only those essential for patient care and procedure support.)	Provisions are comparable with the exception of the OSHA ETS requirement that “The employer must limit the number of employees present during the procedure to only those essential for patient care and procedure support.”
§1910.502(h) Physical distancing.	(1) The employer must ensure that each employee is separated from all other people by at least 6 feet when indoors unless the employer can demonstrate that such physical distancing is not feasible for a specific activity (e.g., hands-on medical care). This provision does not apply to momentary exposure while people are in movement (e.g., passing in hallways or aisles). (2) When the employer establishes it is not feasible for an employee to maintain a distance of at least 6 feet from all other people, the employer must ensure that the employee is as far apart from all other people as feasible. Note to paragraph (h): Physical distancing can include methods such as: telehealth; telework or other remote work arrangements; reducing the number of people, including non-employees, in an area at one time; visual cues such as signs and floor markings to indicate where employees and others should be located or their direction and path of travel; staggered arrival, departure, work, and break	16VAC25-220-30. Definitions 16 VAC25-220-40.D. Mandatory requirements for all employers	"Physical distancing" also called "social distancing" means a person keeping space between himself and other persons while conducting work-related activities inside and outside of the physical establishment by staying at least six feet from other persons. Physical separation of an employee from other employees or persons by a permanent, solid floor to ceiling wall (e.g., an office setting) constitutes one form of physical distancing from an employee or other person stationed on the other side of the wall, provided that six feet of travel distance is maintained from others around the edges or sides of the wall as well. D. Unless otherwise provided in this standard, employers shall establish and implement policies and procedures that ensure employees observe physical distancing while on the job and during paid breaks on the employer's property, including policies and procedures that: 1. Use verbal announcements, signage, or visual cues to promote physical distancing.		The provisions are comparable.

	<p>times; and adjusted work processes or procedures to allow greater distance between employees.</p>	<p>16VAC25-220-40.G Mandatory requirements for all employers</p> <p>16VAC25-220-40.H Mandatory requirements for all employers</p> <p>16VAC25-220-50.C.9 Requirements for hazards or job tasks classified as very high or high exposure risk.</p> <p>16VAC25-220-60.C Requirements for hazards or job tasks classified as medium exposure risk.</p>	<p>2. Decrease worksite density by limiting non-employee access to the place of employment or restrict access to only certain workplace areas to reduce the risk of exposure. An employer's compliance with occupancy limits contained in any applicable Virginia executive order or order of public health emergency will constitute compliance with the requirements in this subsection.</p> <p>G. Where the nature of an employee's work or the work area does not allow the employee to observe physical distancing requirements, employers shall ensure compliance with respiratory protection and personal protective equipment standards applicable to its industry.</p> <p>H. When it is necessary for employees solely exposed to lower risk hazards or job tasks to have brief contact with others inside six feet (e.g., passing another person in a hallway that does not allow physical distancing of six feet), a face covering is required.</p> <p>9. Where feasible, employers shall:</p> <ol style="list-style-type: none"> a. Implement flexible work site (e.g., telework). b. Implement flexible work hours (e.g., staggered shifts). c. Increase physical distancing between employees at the work site to six feet. d. Increase physical distancing between employees and other persons to six feet. e. Implement flexible meeting and travel options (e.g., use telephone or video conferencing instead of in person meetings; postpone non-essential travel or events; etc.). f. Deliver services remotely (e.g. phone, video, internet, etc.). g. Deliver products through curbside pick-up. <p>C. Administrative and work practice controls. To the extent feasible, employers shall implement the following administrative and work practice controls:</p> <ol style="list-style-type: none"> 1. Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19. 2. Provide face coverings to non-employees suspected to be infected with SARS-COV-2 to contain respiratory secretions until the non- 		
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			<p>employees are able to leave the site (i.e., for medical evaluation and care or to return home).</p> <ol style="list-style-type: none"> 3. Implement flexible work site (e.g., telework). 4. Implement flexible work hours (e.g., staggered shifts). 5. Increase physical distancing between employees at the work site to six feet. 6. Increase physical distancing between employees and other persons, including customers, to six feet (e.g., drive-through physical barriers) where such barriers will aid in mitigating the spread of SARS-CoV-2 virus transmission, etc. 7. Implement flexible meeting and travel options (e.g., using telephone or video conferencing instead of in person meetings; postponing non-essential travel or events; etc.). 8. Deliver services remotely (e.g. phone, video, internet, etc.). 9. Deliver products through curbside pick-up or delivery. 10. Employers shall provide and require employees to wear face coverings who, because of job tasks, cannot feasibly practice physical distancing from another employee or other person if the hazard assessment has determined that personal protective equipment, such as respirators or surgical/medical procedure masks, was not required for the job task. 11. Employers shall provide and require employees in customer or other person facing jobs to wear face coverings. 		
§1910.502(i) Physical barriers.	At each fixed work location outside of direct patient care areas (e.g., entryway/lobby, check-in desks, triage, hospital pharmacy windows, bill payment) where each employee is not separated from all other people by at least 6 feet of distance, the employer must install cleanable or disposable solid barriers, except where the employer can demonstrate it is not feasible. The barrier must be sized (e.g., height and width) and located to block face-to-face pathways between individuals based on where each person would normally stand or sit. The barrier may have a pass-through space at the bottom for objects and merchandise. Note to paragraph (i): Physical barriers are not required in direct patient care areas or resident rooms.	16VAC25-220-50.B.7 Requirements for hazards or job tasks classified as very high or high exposure risk: Engineering Controls	<ol style="list-style-type: none"> 7. To the extent feasible, employers shall install physical barriers, (e.g., clear plastic sneeze guards, etc.), where such barriers will aid in mitigating the spread of SARS-CoV-2 virus and COVID-19 disease transmission. <p>(This is also a requirement found in 16VAC25-220-60.B.2.- Requirements for hazards or job tasks classified at medium exposure risk:</p> <ol style="list-style-type: none"> 2. Where feasible, employers shall Install physical barriers (e.g., such as clear plastic sneeze guards, etc.), where such barriers will aid in mitigating the spread of SARS-CoV-2 virus transmission. 	Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (the employer must install cleanable or disposable solid barriers, except where the employer can demonstrate it is not feasible).	<p>The FPS is arguably not as effective as the OSHA ETS.</p> <p>The OSHA ETS requires that each fixed location outside of direct patient care areas where each employee is not separated from other people by at least 6 feet, the employer must install barriers except where the employer can demonstrate it is not feasible.</p>
§1910.502(j) Cleaning and disinfection.	(1) In patient care areas, resident rooms, and for medical devices and equipment, the employer must follow standard practices for cleaning and disinfection of surfaces and equipment in accordance with CDC’s “COVID-19 Infection Prevention and Control	16VAC25-220-40.L Mandatory requirements for all employers:	<p>L. Sanitation and disinfecting.</p> <ol style="list-style-type: none"> 1. In addition to the requirements contained in this standard, employers shall comply with the VOSH sanitation standard applicable to its industry. 		The provisions are comparable.

	<p>Recommendations” and CDC’s “Guidelines for Environmental Infection Control,” pp. 86–103, 147-149 (both incorporated by reference, § 1910.509). (2) In all other areas, the employer must: (i) clean high-touch surfaces and equipment at least once a day, following manufacturers’ instructions for application of cleaners; and (ii) When the employer is aware that a person who is COVID-19 positive has been in the workplace within the last 24 hours, clean and disinfect, in accordance with CDC’s “Cleaning and Disinfecting Guidance” (incorporated by reference, § 1910.509), any areas, materials, and equipment under the employer’s control that have likely been contaminated by the person who is COVID-19 positive (e.g., rooms they occupied, items they touched). (3) The employer must provide alcohol-based hand rub that is at least 60% alcohol or provide readily accessible hand washing facilities.</p>	<p>Sanitation and Disinfecting</p>	<p>2. Employees that interact with customers, the general public, contractors, and other persons shall be provided with and immediately use supplies to clean and disinfectant surfaces contacted during the interaction where there is the potential for exposure to the SARS-CoV-2 virus by themselves or other employees.</p> <p>3. In addition to the requirements contained in this standard, employers shall comply with the VOSH hazard communication standard applicable to the employers' industry for cleaning and disinfecting materials and hand sanitizers.</p> <p>4. Areas in the place of employment where employees or other persons known or suspected to be infected with the SARS-CoV-2 virus accessed or worked shall be cleaned and disinfected prior to allowing other employees access to the areas. Where feasible, a period of 24 hours will be observed prior to cleaning and disinfecting. This requirement shall not apply if the areas in question have been unoccupied for seven or more days.</p> <p>5. All common spaces, including bathrooms (including port-a-johns, privies, etc.), frequently touched surfaces, and doors, shall at a minimum be cleaned and disinfected at least once during or at the end of the shift. Where multiple shifts are employed, such spaces shall be cleaned and disinfected no less than once every 12 hours.</p> <p>6. All shared tools, equipment, workspaces, and vehicles shall be cleaned and disinfected prior to transfer from one employee to another.</p> <p>7. Employers shall ensure that cleaning and disinfecting products are readily available to employees to accomplish the required cleaning and disinfecting. In addition, employers shall ensure use of only disinfecting chemicals and products indicated in the Environmental Protection Agency (EPA) List N for use against SARS-CoV-2, or non-EPA registered disinfectants that otherwise meet the EPA criteria for use against SARS-CoV-2.</p> <p>8. Employers shall ensure that the manufacturer's instructions for use of all disinfecting chemicals and products are complied with (e.g., concentration, application method, contact time, PPE, etc.).</p> <p>9. Employees shall have easy, frequent access and permission to use soap and water, and hand sanitizer where feasible, for the duration of work. Employees assigned to a work station where job tasks require frequent interaction inside six feet with other persons shall be provided with hand sanitizer where feasible at the employees work station.</p> <p>10. Mobile crews shall be provided with hand sanitizer where feasible for the duration of work at a work site or client or customer location and shall have transportation immediately available to nearby toilet facilities and handwashing facilities that meet the requirements of</p>		
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			<p>VOSH laws, standards, and regulations dealing with sanitation. Hand sanitizers required for use to protect against SARS-CoV-2 are flammable, and use and storage in hot environments can result in a hazard.</p> <p>11. It is recognized that various hazards or job tasks at the same place of employment can be designated as very high, high, medium, or lower as presenting potential exposure risk for purposes of application of the requirements of this standard. In situations other than emergencies, employers shall ensure that protective measures are put in place to prevent cross-contamination between tasks, areas, and personnel.</p>		
§1910.502(k) Ventilation.	<p>(1) Employers who own or control buildings or structures with an existing heating, ventilation, and air conditioning (HVAC) system(s) must ensure that: (i) The HVAC system(s) is used in accordance with the HVAC manufacturer's instructions and the design specifications of the HVAC system(s); (ii) The amount of outside air circulated through its HVAC system(s) and the number of air changes per hour are maximized to the extent appropriate; (iii) All air filters are rated Minimum Efficiency Reporting Value (MERV) 13 or higher, if compatible with the HVAC system(s). If MERV-13 or higher filters are not compatible with the HVAC system(s), employers must use filters with the highest compatible filtering efficiency for the HVAC system(s); (iv) All air filters are maintained and replaced as necessary to ensure the proper function and performance of the HVAC system(s); and (v) All intake ports that provide outside air to the HVAC system(s) are cleaned, maintained, and cleared of any debris that may affect the function and performance of the HVAC system(s). (2) Where the employer has an existing AIIR, the employer must maintain and operate it in accordance with its design and construction criteria. Note 1 to paragraph (k): This section does not require installation of new HVAC systems or AIIRs to replace or augment functioning systems. Note 2 to paragraph (k): In addition to the requirements for existing HVAC systems and AIIRs, all employers should also consider other measures to improve ventilation in accordance with "CDC's Ventilation Guidance," (available at www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html) (e.g., opening windows and doors). This could include maximizing</p>	<p>16VAC25-220-50.B Requirements for hazards or job tasks classified as very high or high exposure risk: Engineering Controls</p>	<p>B. Engineering controls. 1. Employers shall ensure that appropriate air-handling systems under their control:</p> <p>a. Are installed and maintained in accordance with the USBC and manufacturer's instructions in healthcare facilities and other places of employment treating, caring for, or housing persons known or suspected to be infected with the SARS-CoV-2 virus; and</p> <p>b. Where feasible and within the design parameters of the system, are utilized as follows:</p> <p>(1) Increase total airflow supply to occupied spaces provided that a greater hazard is not created (e.g., airflow that is increased too much may make doors harder to open or may blow doors open);</p> <p>(2) In ground transportation settings, use natural ventilation to increase outdoor air dilution of inside air in a manner that will aid in mitigating the spread of SARS-CoV2 virus and COVID-19 disease transmission to employees, and when environmental conditions and transportation safety and health requirements allow;</p> <p>(3) Inspect filter housing and racks to ensure appropriate filter fit and check for ways to minimize filter bypass;</p> <p>(4) Increase air filtration to as high as possible in a manner that will still enable the system to provide airflow rates as the system design requires. Ensure compliance with higher filtration values is allowed by the air handler manufacturer's installation instructions and listing;</p> <p>(5) Generate clean-to-less-clean air movements by re-evaluating the positioning of supply and exhaust air diffusers and/or dampers and adjusting zone supply and exhaust flow rates to establish measurable pressure differentials;</p> <p>(6) Have staff work in "clean" ventilation zones that do not include higher-risk areas such as visitor reception or exercise facilities (if open);</p> <p>(7) Ensure exhaust fans in restroom facilities are functional and operating continuously when the building is occupied;</p> <p>(8) If the system's design can accommodate such an adjustment and is allowed by the air handler manufacturer's installation instructions and</p>	<p>[Language highlighted in yellow] Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (where MERV-13 or higher filters are not compatible with the HVAC system(s))</p>	<p>The provisions are comparable with the exception of the OSHA ETS language requiring employer to use filters with highest compatible filtering efficiency if MERV-13 cannot be used</p>

	ventilation in buildings without HVAC systems or in vehicles.		listing, improve central air filtration to MERV-13 and seal edges of the filter to limit bypass; and (9) Check filters to ensure they are within service life and appropriately installed. c. Comply with USBC and applicable referenced American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Standards. NOTE: These ventilation requirements are also found in 16VAC25-220-60.B, Requirements for hazards for job tasks classified at medium exposure risk.		
§1910.502(l) Health screening and medical management.	(1) Screening. (i) The employer must screen each employee before each work day and each shift. Screening may be conducted by asking employees to self-monitor before reporting to work or may be conducted in-person by the employer. (ii) If a COVID-19 test is required by the employer for screening purposes, the employer must provide the test to each employee at no cost to the employee.	16VAC25-220-50.C.1 Requirements for hazards or job tasks classified as very high or high exposure risk. 16VAC25-220-60.C.1 Requirements for hazards or job tasks classified at medium exposure risk 16VAC25-220-40.C.3 Mandatory requirements for all employers.	50.C.1. Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19. 60.C.1. Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19. 40.C.3. For purposes of this section, COVID-19 testing is considered a "medical examination" under § 40.1-28 of the Code of Virginia. Employers shall not require employees to pay for the cost of COVID-19 testing for return to work determinations. If an employer's health insurance covers the entire cost of COVID-19 testing, use of the insurance coverage would not be considered a violation of this subdivision C 3.		The provisions are comparable.
§1910.502(l) Health screening and	(2) Employee notification to employer of COVID-19 illness or symptoms. The employer must require each employee to promptly notify the employer when the employee:	16VAC25-220-40.B.4	4. Employers shall develop and implement policies and procedures for employees to report when they are experiencing signs or symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza). Such employees		The provisions are comparable.

<p>medical management.</p>	<p>(i) is COVID-19 positive (i.e., confirmed positive test for, or has been diagnosed by a licensed healthcare provider with, COVID-19); or (ii) has been told by a licensed healthcare provider that they are suspected to have COVID-19; or (iii) is experiencing recent loss of taste and/or smell with no other explanation; or (iv) is experiencing both fever ($\geq 100.4^{\circ}$ F) and new unexplained cough associated with shortness of breath.</p> <p>(3) Employer notification to employees of COVID-19 exposure in the workplace. (i) Except as provided for in paragraph (1)(3)(iii) of this section, when the employer is notified that a person who has been in the workplace(s) (including employees, clients, patients, residents, vendors, contractors, customers, delivery people and other visitors, or other non-employees) is COVID-19 positive, the employer must, within 24 hours: (A) Notify each employee who was not wearing a respirator and any other required PPE and has been in close contact with that person in the workplace. The notification must state the fact that the employee was in close contact with someone with COVID-19 along with the date(s) that contact occurred.</p> <p>(B) Notify all other employees who were not wearing a respirator and any other required PPE and worked in a well-defined portion of a workplace (e.g., a particular floor) in which that person was present during the potential transmission period. The potential transmission period runs from 2 days before the person felt sick (or, for asymptomatic people, 2 days prior to test specimen collection) until the time the person is isolated. The notification must specify the date(s) the person with COVID-19 was in the workplace during the potential transmission period.</p> <p>(C) Notify other employers whose employees were not wearing respirators and any other required PPE and have been in close contact with that person, or worked in a well-defined portion of a workplace (e.g., a particular floor) in which that person was present, during the potential transmission period.</p> <p>The potential transmission period runs from 2 days before the person felt sick (or, for asymptomatic people, 2 days prior to test specimen collection) until the time the person is isolated. The notification must specify the date(s) the</p>	<p>Mandatory requirements for all employers.</p> <p>16VAC25-220-40.B.7 Mandatory requirements for all employers.</p>	<p>shall be designated by the employer as "suspected to be infected with SARS-CoV-2 virus."</p> <p>To the extent permitted by law, including HIPAA, employers shall establish a system to receive reports of positive SARS-CoV-2 tests by employees, subcontractors, contract employees, and temporary employees (excluding patients hospitalized on the basis of being known or suspected to be infected with SARS-CoV-2 virus) present at the place of employment within two days prior to symptom onset (or positive test if the employee is asymptomatic) until 10 days after onset (or positive test).</p> <p>Employers shall notify:</p> <p>a. The employer's own employees who may have been exposed, within 24 hours of discovery of the employees' possible exposure, while keeping confidential the identity of the person known to be infected with SARS-CoV-2 virus in accordance with the requirements of the Americans with Disabilities Act (ADA) and other applicable federal and Virginia laws and regulations;</p> <p>b. In the same manner as subdivision 7 a of this subsection, other employers whose employees were present at the work site during the same time period;</p> <p>c. In the same manner as subdivision 7 a of this subsection, the building or facility owner. The building or facility owner will require all employer tenants to notify the owner of the occurrence of a SARS-CoV-2-positive test for any employees or residents in the building. This notification will allow the owner to take the necessary steps to sanitize the common areas of the building.</p> <p>In addition, the building or facility owner will notify all employer tenants in the building that one or more cases have been discovered and the floor or work area where the case was located. The identity of the individual will be kept confidential in accordance with the requirements of the Americans with Disabilities Act (ADA) and other applicable federal and Virginia laws and regulations;</p> <p>d. The Virginia Department of Health during a declaration of an emergency by the Governor pursuant to § 44-146.17 of the Code of Virginia. Every employer as defined by § 40.1-2 of the Code of Virginia shall report to the Virginia Department of Health (VDH) when the work site has had two or more confirmed cases of COVID-</p>		<p>The provisions are comparable.</p>
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<p>person with COVID-19 was in the workplace during the potential transmission period and the location(s) where the person with COVID-19 was in the workplace.</p> <p>(ii) The notifications required by paragraph (1)(3)(i) of this section must not include any employee’s name, contact information (e.g., phone number, email address), or occupation.</p> <p>(iii) The notification provisions are not triggered by the presence of a patient with confirmed COVID-19 in a workplace where services are normally provided to suspected or confirmed COVID-19 patients (e.g., emergency rooms, urgent care facilities, COVID-19 testing sites, COVID-19 wards in hospitals).</p> <p>(4) Medical removal from the workplace.</p> <p>(i) If the employer knows an employee meets the criteria listed in paragraph (1)(2)(i) of this section, then the employer must immediately remove that employee and keep the employee removed until they meet the return to work criteria in paragraph (1)(6) of this section.</p> <p>(ii) If the employer knows an employee meets the criteria listed in paragraphs (1)(2)(ii) through (1)(2)(iv) of this section, then the employer must immediately remove that employee and either:</p> <p>(A) Keep the employee removed until they meet the return to work criteria in paragraph (1)(6) of this section; or</p> <p>(B) Keep the employee removed and provide a COVID-19 polymerase chain reaction (PCR) test at no cost to the employee.</p> <p>(1) If the test results are negative, the employee may return to work immediately.</p> <p>(2) If the test results are positive, the employer must comply with paragraph (1)(4)(i) of this section. (3) If the employee refuses to take the test, the employer must</p>	<p>16VAC25-220-40.C. Mandatory requirements for all employers.</p>	<p>19 of its own employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus during that 14-day time period. Employers shall make such a report in a manner specified by VDH, including name, date of birth, and contact information of each case, within 24 hours of becoming aware of such cases. Employers shall continue to report all cases until the local health department has closed the outbreak. After the outbreak is closed, subsequent identification of two or more confirmed cases of COVID-19 during a declared emergency shall be reported, as required by this subdivision B 7 d. The following employers are exempt from this provision because of separate outbreak reporting requirements contained in 12VAC5-90-90: any residential or day program, service, or facility licensed or operated by any agency of the Commonwealth, school, child care center, or summer camp; and</p> <p>e. The Virginia Department of Labor and Industry within 24 hours of the discovery of three or more of its own employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus during that 14-day time period. A reported positive SARS-CoV-2 test does not need to be reported more than once and will not be used for the purpose of identifying more than one grouping of three or more cases, or more than one 14-day period.</p> <p>C. Return to work. Employers shall develop and implement policies and procedures for employees known or suspected to be infected with the SARS-CoV-2 virus to return to work.</p> <p>1. Symptomatic employees known or suspected to be infected with the SARS-CoV-2 virus are excluded from returning to work until all three of the following conditions have been met:</p> <p>a. The employee is fever-free (below 100.0° F) for at least 24 hours, without the use of fever-reducing medications;</p> <p>b. Respiratory symptoms, such as cough and shortness of breath have improved; and</p> <p>c. At least 10 days have passed since symptoms first appeared. However, a limited number of employees with severe illness may produce replication competent virus beyond 10 days that may warrant extending duration of isolation for up to 20 days after symptom onset. Employees who are severely immunocompromised may require testing to determine when they can return to work, and the employer shall consider consultation with infection control experts. VOSH will consult with VDH when identifying severe employee illnesses that may warrant extended duration of isolation or severely immunocompromised employees required to undergo testing.</p>		<p>The provisions are comparable.</p> <p>See DOLI §40, FAQs 24, 25, 26, 27, 28, 29 on isolation, quarantine and return to work issues consistent with CDC updates.</p> <p>https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/</p>
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<p>continue to keep the employee removed from the workplace consistent with paragraph (1)(4)(ii)(A) of this section, but the employer is not obligated to provide medical removal protection benefits in accordance with paragraph (1)(5)(iii) of this section.</p> <p>Absent undue hardship, employers must make reasonable accommodations for employees who cannot take the test for religious or disability-related medical reasons.</p> <p>Note to paragraph (1)(4)(ii): This partial symptom list in paragraphs (1)(2)(iii) and (1)(2)(iv) of this section informs the employer of the minimum requirements for compliance. The full list of COVID-19 symptoms provided by CDC includes additional symptoms not listed in paragraphs (1)(2)(iii) through (1)(2)(iv) of this section. Employers may choose to remove or test employees with additional symptoms from the CDC list, or refer the employees to a healthcare provider.</p> <p>(iii) (A) If the employer is required to notify the employee of close contact in the workplace to a person who is COVID-19 positive in accordance with paragraph (1)(3)(i)(A) of this section, then the employer must immediately remove that employee and either: (1) Keep the employee removed for 14 days; or (2) Keep the employee removed and provide a COVID-19 test at least five days after the exposure at no cost to the employee.</p> <p>(i) If the test results are negative, the employee may return to work after seven days following exposure.</p> <p>(ii) If the test results are positive, the employer must comply with paragraph (1)(4)(i) of this section.</p> <p>(iii) If the employee refuses to take the test, the employer must continue to keep the employee removed from the workplace consistent with paragraph (1)(4)(iii)(A)(1) of this section, but the employer is not obligated to provide medical removal protection benefits in accordance with paragraph (1)(5)(iii) of this section.</p> <p>Absent undue hardship, employers must make reasonable accommodations for employees who cannot take the test for religious or disability-related medical reasons, consistent with applicable non-discrimination laws.</p> <p>(B) Employers are not required to remove any employee who would otherwise be required to be removed under paragraph (i)(4)(iii)(A) of this section if the employee</p>	<p>16VAC25-220-40.C.3. Mandatory requirements for all employers.</p> <p>16VAC25-220-40.B.5. Mandatory requirements for all employers.</p>	<p>2. Employees known to be infected with SARS-CoV-2 who never develop signs or symptoms are excluded from returning to work until 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.</p> <p>C.3. For purposes of this section, COVID-19 testing is considered a "medical examination" under § 40.1-28 of the Code of Virginia. Employers shall not require employees to pay for the cost of COVID-19 testing for return to work determinations. If an employer's health insurance covers the entire cost of COVID-19 testing, use of the insurance coverage would not be considered a violation of this subdivision C 3.</p> <p>B.5. Employers shall not permit employees or other persons known or suspected to be infected with SARS-CoV-2 virus to report to or remain at the work site or engage in work at a customer or client location until cleared for return to work (see subsection C of this section). Nothing in this standard shall prohibit an employer from permitting an employee known or suspected to be infected with SARS-CoV-2 virus from engaging in teleworking or other form of work isolation that would not result in potentially exposing other employees to the SARS-CoV-2 virus.</p>		<p>The provisions are comparable.</p> <p>The provisions are comparable.</p>
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<p>does not experience the symptoms in paragraph (1)(2)(iii) or (1)(2)(iv) of this section and has:</p> <p>(1) been fully vaccinated against COVID-19 (i.e., 2 weeks or more following the final dose); or</p> <p>(2) had COVID-19 and recovered within the past 3 months.</p> <p>(iv) Any time an employee is required to be removed from the workplace for any reason under paragraph (1)(4) of this section, the employer may require the employee to work remotely or in isolation if suitable work is available.</p> <p>(5) Medical removal protection benefits.</p> <p>(i) Employers with 10 or fewer employees on the effective date of this section are not required to comply with paragraphs (1)(5)(iii) through (1)(5)(iv) of this section. (ii) When an employer allows an employee to work remotely or in isolation in accordance with paragraph (1)(4)(iv) of this section, the employer must continue to pay the employee the same regular pay and benefits the employee would have received had the employee not been absent from work, until the employee meets the return to work criteria specified in paragraph (1)(4)(iii) or (1)(6) of this section.</p> <p>(iii) When an employer removes an employee in accordance with paragraph (1)(4) of this section: (A) the employer must continue to provide the benefits to which the employee is normally entitled and must also pay the employee the same regular pay the employee would have received had the employee not been absent from work, up to \$1,400 per week, until the employee meets the return to work criteria specified in paragraph (1)(4)(iii) or (1)(6) of this section.</p> <p>(B) For employers with fewer than 500 employees, the employer must pay the employee up to the \$1,400 per week cap but, beginning in the third week of an employee's removal, the amount is reduced to only two-thirds of the same regular pay the employee would have received had the employee not been absent from work, up to \$200 per day (\$1,000 per week in most cases).</p> <p>(iv) The employer's payment obligation under paragraph (1)(5)(iii) of this section is reduced by the amount of compensation that the employee receives from any other source, such as a publicly or employer-funded</p>		<p>No comparable provision in the FPS.</p>	<p>Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (medical removal benefits)</p>	
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<p>compensation program (e.g., paid sick leave, administrative leave), for earnings lost during the period of removal or any additional source of income the employee receives that is made possible by virtue of the employee's removal. (v) Whenever an employee returns to the workplace after a COVID-19-related workplace removal, that employee must not suffer any adverse action as a result of that removal from the workplace and must maintain all employee rights and benefits, including the employee's right to their former job status, as if the employee had not been removed.</p> <p>(6) Return to work. The employer must make decisions regarding an employee's return to work after a COVID-19-related workplace removal in accordance with guidance from a licensed healthcare provider or CDC's "Isolation Guidance" (incorporated by reference, § 1910.509); and CDC's "Return to Work Healthcare Guidance" (incorporated by reference, § 1910.509). Note to paragraph (1): OSHA recognizes that CDC's "Strategies to Mitigate Healthcare Personnel Staffing Shortages" (available at www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html) allows elimination of quarantine for certain healthcare workers, but only as a last resort, if the workers' absence would mean there are no longer enough staff to provide safe patient care, specific other amelioration strategies have already been tried, patients have been notified, and workers are utilizing additional PPE at all times</p>	<p>16VAC25-220-40.B.5. Mandatory requirements for all employers.</p> <p>16VAC25-220-40.C. Mandatory requirements for all employers.</p>	<p>5. Employers shall not permit employees or other persons known or suspected to be infected with SARS-CoV-2 virus to report to or remain at the work site or engage in work at a customer or client location until cleared for return to work (see subsection C of this section). Nothing in this standard shall prohibit an employer from permitting an employee known or suspected to be infected with SARS-CoV-2 virus from engaging in teleworking or other form of work isolation that would not result in potentially exposing other employees to the SARS-CoV-2 virus.</p> <p>C. Return to work. Employers shall develop and implement policies and procedures for employees known or suspected to be infected with the SARS-CoV-2 virus to return to work.</p> <p>1. Symptomatic employees known or suspected to be infected with the SARS-CoV-2 virus are excluded from returning to work until all three of the following conditions have been met:</p> <ul style="list-style-type: none"> a. The employee is fever-free (below 100.0° F) for at least 24 hours, without the use of fever-reducing medications; b. Respiratory symptoms, such as cough and shortness of breath have improved; and c. At least 10 days have passed since symptoms first appeared. <p>However, a limited number of employees with severe illness may produce replication-competent virus beyond 10 days that may warrant extending duration of isolation for up to 20 days after symptom onset. Employees who are severely immunocompromised may require testing to determine when they can return to work, and the employer shall consider consultation with infection control experts. VOSH will consult with VDH when identifying severe employee illnesses that may warrant extended duration of isolation or severely immunocompromised employees required to undergo testing.</p> <p>2. Employees known to be infected with SARS-CoV-2 who never develop signs or symptoms are excluded from returning to work until</p>	<p>The provisions are comparable.</p> <p>The Department has issued FAQs addressing the CDC's updates concerning persons who are fully vaccinated (see §10, FAQs 19-22, and §40, FAQs 46-54).</p> <p>https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/</p>	
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			10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.		
§1910.502(m) Vaccination.	The employer must support COVID-19 vaccination for each employee by providing reasonable time and paid leave (e.g., paid sick leave, administrative leave) to each employee for vaccination and any side effects experienced following vaccination.		No comparable provision in the FPS.	Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (paid leave for vaccinations)	
§1910.502(n) Training.	(1) The employer must ensure that each employee receives training, in a language and at a literacy level the employee understands , and so that the employee comprehends at least the following: (i) COVID-19, including how the disease is transmitted (including presymptomatic and asymptomatic transmission), the importance of hand hygiene to reduce the risk of spreading COVID-19 infections, ways to reduce the risk of spreading COVID-19 through the proper covering of the nose and mouth, the signs and symptoms of the disease, risk factors for severe illness, and when to seek medical attention; (ii) employer-specific policies and procedures on patient screening and management; (iii) tasks and situations in the workplace that could result in COVID-19 infection; (iv) workplace-specific policies and procedures to prevent the spread of COVID19 that are applicable to the employee’s duties (e.g., policies on Standard and Transmission-Based Precautions, physical distancing, physical barriers, ventilation, aerosol-generating procedures); (v) employer-specific multi-employer workplace agreements related to infection control policies and procedures, the use of common areas, and the use of shared equipment that affect employees at the workplace; (vi) employer-specific policies and procedures for PPE worn to comply with this section, including: (A) when PPE is required for protection against COVID-19; (B) limitations of PPE for protection against COVID-19; (C) how to properly put on, wear, and take off PPE; (D) how to properly care for, store, clean, maintain, and dispose of PPE; and	16VAC25-220-80 Training	A. Employers with hazards or job tasks classified as very high, high, or medium exposure risk at a place of employment shall provide training on the hazards and characteristics of the SARSCoV-2 virus and COVID-19 disease to all employees working at the place of employment regardless of employee risk classification. The training program shall enable each employee to recognize the hazards of the SARS-CoV-2 virus and signs and symptoms of COVID-19 disease and shall train each employee in the procedures to be followed in order to minimize these hazards. B. The training required under subsection A of this section shall include: 1. The requirements of this standard; 2. The mandatory and non-mandatory provisions in any applicable CDC guidelines or Commonwealth of Virginia guidance documents the employer is complying with, if any, in lieu of a provision of this standard as provided for in 16VAC25-220-10 E, F, and G; 3. The characteristics and methods of transmission of the SARS-CoV-2 virus; 4. The signs and symptoms of COVID-19 disease; 5. Risk factors for severe COVID-19 illness including underlying health conditions and advancing age; 6. Awareness of the ability of persons pre-symptomatically and asymptotically infected with SARS-CoV-2 to transmit the SARS-CoV-2 virus; 7. Safe and healthy work practices, including, but not limited to, physical distancing, the wearing of face coverings, disinfection procedures, disinfecting frequency, ventilation, noncontact methods of greeting, etc.; 8. Personal protective equipment (PPE): a. When PPE is required; b. What PPE is required;		See DOLI §80, FAQ 1 on employer requirement “to present information in a manner that their employees can understand.” https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

			<p>1. Changes in the workplace, SARS-CoV-2 virus or COVID-19 disease hazards exposed to, or job tasks performed render previous training obsolete;</p> <p>2. Changes are made to the employer's Infectious Disease Preparedness and Response Plan; or</p> <p>3. Inadequacies in an affected employee's knowledge or use of workplace control measures indicate that the employee has not retained the requisite understanding or skill.</p> <p>E. Employers with hazards or job tasks classified at lower risk shall provide written or oral information to employees exposed to such hazards or engaged in such job tasks on the hazards and characteristics of SARS-COV-2 and the symptoms of COVID-19 and measures to minimize exposure. The Department of Labor and Industry shall develop an information sheet containing information on the items listed in subsection F of this section, which an employer may utilize to comply with this subsection.</p> <p>F. The information required under subsection E of this section shall include at a minimum:</p> <ol style="list-style-type: none"> 1. The requirements of this standard; 2. The characteristics and methods of transmission of the SARS-CoV-2 virus; 3. The signs and symptoms of COVID-19 disease; 4. The ability of persons pre-symptomatically and asymptotically infected with SARSCoV-2 to transmit the SARS-CoV-2 virus; 5. Safe and healthy work practices and control measures, including, but not limited to, physical distancing, the benefits of wearing face coverings, sanitation and disinfection practices; and 6. The anti-discrimination provisions of this standard in 16VAC25-220-90. 	<p>knowledgeable in the covered subject matter)</p>	<p>provides an opportunity for interactive questions and answers with a person knowledgeable in the covered subject matter as it relates to the employee's job duties.</p>
<p>§1910.502(o) Retaliation</p>	<p>(o) Anti-Retaliation. (1) The employer must inform each employee that: (i) employees have a right to the protections required by this section; and (ii) employers are prohibited from discharging or in any manner discriminating against any employee for exercising their right to the protections required by this section, or for engaging in actions that are required by this section. (2) The employer must not discharge or in any manner discriminate against any employee for exercising their right to the protections required by this section, or for engaging in actions that are required by this section.</p>	<p>16VAC25-220-90. Discrimination against an employee for exercising rights under this standard is prohibited.</p>	<p>A. No person shall discharge or in any way discriminate against an employee because the employee has exercised rights under the safety and health provisions of this standard, Title 40.1 of the Code of Virginia, and implementing regulations under 16VAC25-60-110 for themselves or others.</p> <p>B. No person shall discharge or in any way discriminate against an employee who voluntarily provides and wears the employee's own personal protective equipment, including, but not limited to, a respirator, face shield, gown, or gloves, provided that the PPE does not create a greater hazard to the employee or create a serious hazard for other employees. In situations where face coverings are not provided by the employer, no person shall discharge or in any way</p>		<p>The provisions are similar but not identical.</p>

	Note to paragraph (o): In addition, section 11(c) of the OSH Act also prohibits the employer from discriminating against an employee for exercising rights under, or as a result of actions that are required by, this section. That provision of the Act also protects the employee who files a safety and health complaint, or otherwise exercises any rights afforded by the OSH Act.		<p>discriminate against an employee who voluntarily provides and wears the employee's own face covering that meets the requirements of this standard, provided that the face covering does not create a greater hazard to the employee or create a serious hazard for other employees. Nothing in this subsection shall be construed to prohibit an employer from establishing and enforcing legally permissible dress code or similar requirements addressing the exterior appearance of personal protective equipment or face coverings.</p> <p>C. No person shall discharge or in any way discriminate against an employee who raises a reasonable concern about infection control related to the SARS-CoV-2 virus and COVID-19 disease to the employer, the employer's agent, other employees, a government agency, or to the public such as through print, online, social, or any other media.</p> <p>D. Nothing in this standard shall limit an employee from refusing to do work or enter a location because of a reasonable fear of illness or death. The requirements of 16VAC25-60-110 contain the applicable requirements concerning discharge or discipline of an employee who has refused to complete an assigned task because of a reasonable fear of illness or death.</p> <p>16VAC25-220-80. Training. B. The training required under subsection A of this section shall include: 9. The anti-discrimination provisions in 16VAC25-220-90;</p>		
§1910.502(p) Requirements implemented at no cost to employees.	(p) Requirements implemented at no cost to employees. The implementation of all requirements of this section, with the exception of any employee self-monitoring conducted under paragraph (l)(1)(i) of this section, must be at no cost to employees.		No comparable section in FPS.	Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (Requirements implemented at no cost to employees)	
§1910.502(q) Recordkeeping .	(q) Recordkeeping. (1) Small employer exclusion. Employers with 10 or fewer employees on the effective date of this section are not required to comply with paragraph (q)(2) or (q)(3) of this section.	16VAC25-220-40. Mandatory requirements for all employers	16VAC25-220-40.B.7.a-c 7. To the extent permitted by law, including HIPAA, employers shall establish a system to receive reports of positive SARS-CoV-2 tests by employees, subcontractors, contract employees, and temporary employees (excluding patients hospitalized on the basis of being known or suspected to be infected with SARS-CoV-2 virus) present at the place of employment within two days prior to symptom onset (or	Possible ALAEA issue when comparing recordkeeping requirements in the OSHA ETS to any recordkeeping requirements in the FPS applicable to the	The ETS requires a specific COVID-19 log to be created and maintained by ER The FPS does require ER to establish a system to

<p>(2) Required records. Employers with more than 10 employees on the effective date of this section must: (i) retain all versions of the COVID-19 plan implemented to comply with this section while this section remains in effect.</p> <p>(ii) establish and maintain a COVID-19 log to record each instance identified by the employer in which an employee is COVID-19 positive, regardless of whether the instance is connected to exposure to COVID-19 at work. (A) The COVID-19 log must contain, for each instance, the employee’s name, one form of contact information, occupation, location where the employee worked, the date of the employee’s last day at the workplace, the date of the positive test for, or diagnosis of, COVID-19, and the date the employee first had one or more COVID-19 symptoms, if any were experienced. (B) The information in the COVID-19 log must be recorded within 24 hours of the employer learning that the employee is COVID-19 positive and must be maintained as though it is a confidential medical record and must not be disclosed except as required by this ETS or other federal law. (C) The COVID-19 log must be maintained and preserved while this section remains in effect. Note to paragraph (q)(2)(ii): The COVID-19 log is intended to assist employers with tracking and evaluating instances of employees who are COVID-19 positive without regard to whether those employees were infected at work. The tracking will help evaluate potential workplace exposure to other employees.</p> <p>(3) Availability of records. By the end of the next business day after a request, the employer must provide, for examination and copying:</p> <p>(i) All versions of the written COVID-19 plan to all of the following: any employees, their personal representatives, and their authorized representatives.</p> <p>(ii) The individual COVID-19 log entry for a particular employee to that employee and to anyone having written authorized consent of that employee. (iii) A version of the COVID-19 log that removes the names of employees, contact information, and occupation, and only includes, for each employee in the COVID-19 log, the location where the employee worked, the last day that the employee was at the workplace before removal, the date</p>		<p>positive test if the employee is asymptomatic) until 10 days after onset (or positive test). Employers shall notify:</p> <p>a. The employer's own employees who may have been exposed, within 24 hours of discovery of the employees' possible exposure, while keeping confidential the identity of the person known to be infected with SARS-CoV-2 virus in accordance with the requirements of the Americans with Disabilities Act (ADA) and other applicable federal and Virginia laws and regulations;</p> <p>b. In the same manner as subdivision 7 a of this subsection, other employers whose employees were present at the work site during the same time period;</p> <p>c. In the same manner as subdivision 7 a of this subsection, the building or facility owner. The building or facility owner will require all employer tenants to notify the owner of the occurrence of a SARS-CoV-2-positive test for any employees or residents in the building. This notification will allow the owner to take the necessary steps to sanitize the common areas of the building. In addition, the building or facility owner will notify all employer tenants in the building that one or more cases have been discovered and the floor or work area where the case was located. The identity of the individual will be kept confidential in accordance with the requirements of the Americans with Disabilities Act (ADA) and other applicable federal and Virginia laws and regulations;</p>	<p>healthcare industry (COVID-19 log)</p>	<p>receive reports of positive COVID tests by EEs and notification requirements for ER to notify all EEs potentially exposed in the workplace; however, there is no specific COVID log requirement.</p>
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	<p>of that employee’s positive test for, or diagnosis of, COVID-19, and the date the employee first had one or more COVID-19 symptoms, if any were experienced, to all of the following: any employees, their personal representatives, and their authorized representatives.</p> <p>(iv) All records required to be maintained by this section to the Assistant Secretary. Note to paragraph (q): Employers must continue to record all work-related confirmed cases of COVID-19 on their OSHA Forms 300, 300A, and 301, or the equivalent forms, if required to do so under 29 CFR part 1904.</p>				
<p>§1910.502(r) Reporting COVID-19 fatalities and hospitalizations to OSHA.</p>	<p>(r) Reporting COVID-19 fatalities and hospitalizations to OSHA.</p> <p>(1) The employer must report to OSHA: (i) Each work-related COVID-19 fatality within 8 hours of the employer learning about the fatality. (ii) Each work-related COVID-19 in-patient hospitalization within 24 hours of the employer learning about the in-patient hospitalization.</p> <p>(2) When reporting COVID-19 fatalities and in-patient hospitalizations to OSHA in accordance with paragraph (r)(1) of this section, the employer must follow the requirements in 29 CFR part 1904.39, except for 29 CFR part 1904.39(a)(1) and (2) and (b)(6).</p>	<p>Va. Code §40.1-51.1(D)</p> <p>16VAC25-220-40.B.7.d and 7.e Mandatory requirements for all employers.</p>	<p>Va. Code §40.1-51.1(D). § 40.1-51.1. Duties of employers.</p> <p>....</p> <p>D. Every employer shall report to the Virginia Department of Labor and Industry within eight hours any work-related incident resulting in a fatality or within 24 hours any work-related incident resulting in (i) the inpatient hospitalization of one or more persons, (ii) an amputation, or (iii) the loss of an eye, as prescribed in the rules and regulations of the Safety and Health Codes Board.</p> <p>7. To the extent permitted by law, including HIPAA, employers shall establish a system to receive reports of positive SARS-CoV-2 tests by employees, subcontractors, contract employees, and temporary employees (excluding patients hospitalized on the basis of being known or suspected to be infected with SARS-CoV-2 virus) present at the place of employment within two days prior to symptom onset (or positive test if the employee is asymptomatic) until 10 days after onset (or positive test). Employers shall notify:</p> <p>...</p> <p>d. The Virginia Department of Health during a declaration of an emergency by the Governor pursuant to § 44-146.17 of the Code of Virginia. Every employer as defined by § 40.1-2 of the Code of Virginia shall report to the Virginia Department of Health (VDH) when the work site has had two or more confirmed cases of COVID-19 of its own employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus during that 14-day time period. Employers shall make such a report in a manner specified by VDH, including name, date of birth, and contact information of each case, within 24 hours of becoming aware of such</p>		

			<p>cases. Employers shall continue to report all cases until the local health department has closed the outbreak. After the outbreak is closed, subsequent identification of two or more confirmed cases of COVID-19 during a declared emergency shall be reported, as required by this subdivision B 7 d. The following employers are exempt from this provision because of separate outbreak reporting requirements contained in 12VAC5- 90-90: any residential or day program, service, or facility licensed or operated by any agency of the Commonwealth, school, child care center, or summer camp; and</p> <p>e. The Virginia Department of Labor and Industry within 24 hours of the discovery of three or more of its own employees present at the place of employment within a 14- day period testing positive for SARS-CoV-2 virus during that 14-day time period. A reported positive SARS-CoV-2 test does not need to be reported more than once and will not be used for the purpose of identifying more than one grouping of three or more cases, or more than one 14-day period.</p>		
§1910.502(s) Dates	<p>(s) Dates.</p> <p>(1) Effective date. This section is effective as of [INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER].</p> <p>(2) Compliance dates. (i) Employers must comply with all requirements of this section, except for requirements in paragraph (i), paragraph (k), and paragraph (n) of this section by [INSERT DATE 14 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]. (ii) Employers must comply with the requirements of this section in paragraph (i), paragraph (k), and paragraph (n) of this section by [INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER].</p>	16VAC25-220-20. Effective dates.	<p>A.5. Effective date is January 27, 2021.</p> <p>B. The requirements for 16VAC25-220-70 shall take effect on March 26, 2021. The training requirements in 16VAC25-220-80 shall take effect on March 26, 2021.</p>		
§1910.504(a) Mini Respiratory Protection Program.	<p>§ 1910.504 Mini Respiratory Protection Program.</p> <p>(a) Scope and application. This section applies only to respirator use in accordance with § 1910.502 (f)(4). (see below)</p> <p>ETS § 1910.502 (f)(4). Use of respirators when not required.</p> <p>(i) The employer <i>may</i> provide a respirator to the employee instead of a facemask as required by paragraph (f)(1) of this section. In such circumstances, the employer</p>	16VAC25-220-50.D. Requirements for hazards or job tasks classified as very high or high exposure risk.	<p>50.D. Personal protective equipment (PPE). Employers covered by this section and not otherwise covered by the VOSH Standards for General Industry (16VAC25-90-1910.132), shall comply with the following requirements for a SARS-CoV-2 virus and COVID-19 disease-related hazard assessment and personal protective equipment selection:</p> <p>1. Employers shall assess the workplace to determine if SARS-CoV-2 virus or COVID-19 disease hazards or job tasks are present or are likely to be present that necessitate the use of personal protective</p>	Possible ALAEA issue when comparing requirements in the OSHA ETS to requirements in the FPS applicable to the healthcare industry (mini respiratory protection program)	OSHA refers to this section as the “mini” respiratory protection program” because it is a less detailed hybrid of the respiratory protection program normally required under 19.132.

	<p>must comply with § 1910.504. (ii) Where the employer provides the employee with a facemask as required by paragraph (f)(1) of this section, the employer must permit the employee to wear their own respirator instead of a facemask. In such circumstances, the employer must also comply with § 1910.504</p>		<p>equipment (PPE). Employers shall provide for employee and employee representative involvement in the assessment process. If such hazards or job tasks are present or likely to be present, employers shall: a. Except as otherwise required in the standard, select and have each affected employee use the types of PPE that will protect the affected employee from the SARS-CoV-2 virus or COVID-19 disease hazards identified in the hazard assessment; b. Communicate selection decisions to each affected employee; and c. Select PPE that properly fits each affected employee</p> <p>3. Unless specifically addressed by an industry specific standard applicable to the employer and providing for PPE protections to employees from the SARS-COV-2 virus or COVID-19 disease (e.g., 16VAC25-175-1926, 16VAC25-190-1928, 16VAC25-100-1915, 16VAC25-120-1917, or 16VAC25-130-1918), the requirements of 16VAC25-90-1910.132 (General requirements) and 16VAC25-90-1910.134 (Respiratory protection) shall apply to all employers for that purpose.</p> <p>4. Unless contraindicated by a hazard assessment and equipment selection requirements in subdivision 1 of this subsection, employees classified as very high or high exposure risk shall be provided with and wear gloves, a gown, a face shield or goggles, and a respirator when in contact with or inside six feet of patients or other persons known to be or suspected of being infected with SARS-CoV-2. Gowns shall be the correct size to assure protection.</p>		<p>FPS requires employers to assess hazard and select and provide PPE as appropriate.</p> <p>FPS references industry standards or respiratory requirements of 16VAC25-90-1910.132 (General requirements) and 16VAC25-90-1910.134 (Respiratory protection) shall apply to all employers for that purpose.</p>
<p>§1910.504(b) Definitions</p>	<p>(b) Definitions. The following definitions apply to this section:</p> <p>COVID-19 (Coronavirus Disease 2019) means the respiratory disease caused by SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2). For clarity and ease of reference, this section refers to “COVID-19” when describing exposures or potential exposures to SARS-CoV-2.</p> <p>Elastomeric respirator means a tight-fitting respirator with a facepiece that is made of synthetic or rubber material that permits it to be disinfected, cleaned, and reused according to manufacturer’s instructions. It is equipped with a replaceable cartridge(s), canister(s), or filter(s).</p>	<p>16VAC25-220-30. Definitions.</p>	<p>See below FPS definitions that correspond to ETS definitions in this section.</p> <p>See response above to definition of "COVID-19"</p> <p>See response above to definition of “Elastomeric respirator”</p>		

<p>Filtering facepiece respirator means a negative-pressure particulate respirator with a non-replaceable filter as an integral part of the facepiece or with the entire facepiece composed of the non-replaceable filtering medium.</p> <p>Hand hygiene means the cleaning and/or disinfecting of one's hands by using standard handwashing methods with soap and running water or an alcohol-based hand rub that is at least 60% alcohol.</p> <p>Respirator means a type of personal protective equipment (PPE) that is certified by the National Institute for Occupational Safety and Health (NIOSH) under 42 CFR part 84 or is authorized under an Emergency Use Authorization (EUA) by the US Food and Drug Administration. Respirators protect against airborne hazards by removing specific air contaminants from the ambient (surrounding) air or by supplying breathable air from a safe source. Common types of respirators include filtering facepiece respirators, elastomeric respirators, and PAPRs. Face coverings, facemasks, and face shields are not respirators.</p> <p>Powered air-purifying respirator (PAPR) means an air-purifying respirator that uses a blower to force the ambient air through air-purifying elements to the inlet covering.</p> <p>Tight-fitting respirator means a respirator in which the air pressure inside the facepiece is negative during inhalation with respect to the ambient air pressure outside the respirator (e.g., filtering facepiece).</p> <p>User seal check means an action conducted by the respirator user to determine if the respirator is properly seated to the face.</p>			<p>See response above to definition of "Filtering facepiece respirator"</p> <p>See response above to definition of "Hand hygiene"</p> <p>See response above to definition of "Respirator"</p> <p>See response above to definition of "Powered air-purifying respirator"</p> <p>See response above to definition of "Respirator" which contains a definition of "tight-fitting" respirator</p> <p>No comparable definition in FPS</p> <p>However, the term is defined in 1910.134, Respiratory Protection Standard, which applies in Virginia:</p> <p>"User seal check means an action conducted by the respirator user to determine if the respirator is properly seated to the face."</p> <p>https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134</p>		<p>The term is defined in 1910.134, Respiratory Protection Standard, which applies in Virginia</p>
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<p>§1910.504(c) Respirators provided by employees.</p>	<p>(c) Respirators provided by employees. Where employees provide and use their own respirators, the employer must provide each employee with the following notice: Respirators can be an effective method of protection against COVID-19 hazards when properly selected and worn. Respirator use is encouraged to provide an additional level of comfort and protection for workers even in circumstances that do not require a respirator to be used. However, if a respirator is used improperly or not kept clean, the respirator itself can become a hazard to the worker. If your employer allows you to provide and use your own respirator, you need to take certain precautions to be sure that the respirator itself does not present a hazard. You should do the following: (1) Read and follow all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirator's limitations. (2) Keep track of your respirator so that you do not mistakenly use someone else's respirator; (3) Do not wear your respirator where other workplace hazards (e.g., chemical exposures) require use of a respirator. In such cases, your employer must provide you with a respirator that is used in accordance with OSHA's respiratory protection standard (29 CFR part 1910.134). For more information about using a respirator, see OSHA's respiratory protection safety and health topics page (https://www.osha.gov/respiratory-protection).</p>	<p>16VAC25-220-90.B. Discrimination against an employee for exercising rights under this standard is prohibited.</p>	<p>16VAC25-220-90.B No person shall discharge or in any way discriminate against an employee who voluntarily provides and wears the employee's own personal protective equipment, including, but not limited to, a respirator, face shield, gown, or gloves, provided that the PPE does not create a greater hazard to the employee or create a serious hazard for other employees. In situations where face coverings are not provided by the employer, no person shall discharge or in any way discriminate against an employee who voluntarily provides and wears the employee's own face covering that meets the requirements of this standard, provided that the face covering does not create a greater hazard to the employee or create a serious hazard for other employees. Nothing in this subsection shall be construed to prohibit an employer from establishing and enforcing legally permissible dress code or similar requirement addressing the exterior appearance of personal protective equipment or face coverings. (Emphasis added).</p>		<p>See DOLI §90, FAQ 3 https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/</p>
<p>§1910.504(d) Respirators provided by employers.</p>	<p>(d) Respirators provided by employers. Where employers provide respirators to their employees, the employer must comply with the following requirements: (1) Training. The employer must ensure that each employee wearing a respirator receives training prior to first use and if they change the type of respirator, in a language and at a literacy level the employee understands, and comprehends at least the following: (i) How to inspect, put on and remove, and use a respirator; (ii) The limitations and capabilities of the respirator, particularly when the respirator has not been fit tested; (iii) Procedures and schedules for storing, maintaining, and inspecting respirators; (iv) How to perform a user seal check as described in paragraph (d)(2) of this section; and (v) How to recognize medical signs and symptoms that may limit or prevent the effective use of</p>	<p>16VAC25-220-50.D. 1 & 4. Requirements for hazards or job tasks classified as very high or high exposure risk.</p>	<p>16VAC25-220-50.D. D. Personal protective equipment (PPE). Employers covered by this section and not otherwise covered by the VOSH Standards for General Industry (16VAC25-90-1910.132), shall comply with 40 the following requirements for a SARS-CoV-2 virus and COVID-19 disease-related hazard assessment and personal protective equipment selection: 1. Employers shall assess the workplace to determine if SARS-CoV-2 virus or COVID-19 disease hazards or job tasks are present or are likely to be present that necessitate the use of personal protective equipment (PPE). Employers shall provide for employee and employee representative involvement in the assessment process. If such hazards or job tasks are present or likely to be present, employers shall: a. Except as otherwise required in the standard, select and have each affected employee use the types of PPE that will</p>		<p>OSHA refers to this section as the "mini" respiratory protection program" because it is a less detailed hybrid of the respiratory protection program normally required under 19.132. The OSHA ETS outlines specific but lessened requirements when respirators are provided by the employers, such as training, seal checks, reuse of respirators and</p>

<p>respirators and what to do if the employee experiences signs and symptoms. (2) User seal check. (i) The employer must ensure that each employee who uses a tight-fitting respirator performs a user seal check to ensure that the respirator is properly seated to the face each time the respirator is put on. Acceptable methods of user seal checks include: (A) Positive pressure user seal check (i.e., blow air out). Once you have conducted proper hand hygiene and properly donned the respirator, place your hands over the facepiece, covering as much surface area as possible. Exhale gently into the facepiece. The face fit is considered satisfactory if a slight positive pressure is being built up inside the facepiece without any evidence of outward leakage of air at the seal. Examples of evidence that it is leaking could be the feeling of air movement on your face along the seal of the facepiece, fogging of your glasses, or a lack of pressure being built up inside the facepiece. If the particulate respirator has an exhalation valve, then performing a positive pressure check may not be possible unless the user can cover the exhalation valve. In such cases, a negative pressure check must be performed. (B) Negative pressure user seal check (i.e., suck air in). Once you have conducted proper hand hygiene and properly donned the respirator, cover the filter surface with your hands as much as possible and then inhale. The facepiece should collapse on your face and you should not feel air passing between your face and the facepiece. (ii) The employer must ensure that each employee corrects any problems discovered during the user seal check. In the case of either type of user seal check (positive or negative), if air leaks around the nose, use both hands to readjust how the respirator sits on your face or adjust the nosepiece, if applicable. Readjust the straps along the sides of your head until a proper seal is achieved. Note to paragraph (d)(2)(i) and (ii): When employees are required to wear a respirator and a problem with the seal check arises due to interference with the seal by an employee’s facial hair, employers may provide a different type of respirator to accommodate employees who cannot trim or cut facial hair due to religious belief. (3) Reuse of respirators. (i) The employer must ensure that a filtering facepiece respirator used by a particular employee is only reused by that employee, and only when: (A) the respirator is not</p>		<p>protect the affected employee from the SARS-CoV-2 virus or COVID-19 disease hazards identified in the hazard assessment; b. Communicate selection decisions to each affected employee; and c. Select PPE that properly fits each affected employee. 4. Unless contraindicated by a hazard assessment and equipment selection requirements in subdivision 1 of this subsection, employees classified as very high or high exposure risk shall be provided with and wear gloves, a gown, a face shield or goggles, and a respirator when in contact with or inside six feet of patients or other persons known to be or suspected of being infected with SARS-CoV-2. Gowns shall be the correct size to assure protection.</p>		<p>guidance for discontinuing use of a respirator. The FPS covers assessment of PPE and the requirement to employers to determine and select appropriate PPE and provide respirators to employees in the high exposure risk categories. FPS incorporates by reference 16VAC25-90-1910.134 (Respiratory protection). There is no COVID-19 specific respiratory requirements such as the one outlined in the ETS.</p>
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	<p>visibly soiled or damaged; (B) the respirator has been stored in a breathable storage container (e.g., paper bag) for at least five calendar days between use and has been kept away from water or moisture; (C) the employee does a visual check in adequate lighting for damage to the respirator's fabric or seal; (D) the employee successfully completes a user seal check as described in paragraph (d)(2) of this section; (E) the employee uses proper hand hygiene before putting the respirator on and conducting the user seal check; and (F) the respirator has not been worn more than five days total. Note to paragraph (d)(3)(i): The reuse of single-use respirators (e.g., filtering facepiece respirators) is discouraged. (ii) The employer must ensure that an elastomeric respirator or PAPR is only reused when: (A) the respirator is not damaged; (B) the respirator is cleaned and disinfected as often as necessary to be maintained in a sanitary condition in accordance with § 1910.134, Appendix B-2; and (C) a change schedule is implemented for cartridges, canisters, or filters.</p> <p>(4) Discontinuing use of respirators. Employers must require employees to discontinue use of a respirator when either the employee or a supervisor reports medical signs or symptoms (e.g., shortness of breath, coughing, wheezing, chest pain, any other symptoms related to lung problems, cardiovascular symptoms) that are related to ability to use a respirator. Any employee who previously had a medical evaluation and was determined to not be medically fit to wear a respirator must not be provided with a respirator under this standard unless they are reevaluated and medically cleared to use a respirator.</p>				
§1910.504(e) Effective date	(e) Effective date. This section is effective as of [INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER].	16VAC25-220-20. Effective dates.	<p>A.5. The Governor reviewed the standard under subdivision A 1 of this section and the effective date is January 27, 2021.</p> <p>B. The requirements for 16VAC25-220-70 shall take effect on March 26, 2021. The training requirements in 16VAC25-220-80 shall take effect on March 26, 2021.</p>		
§1910.505 Severability.	§ 1910.505 Severability. Each section of this subpart U, and each provision within those sections, is separate and severable from the other sections and provisions. If any provision of this subpart is held to be invalid or unenforceable on its face, or as applied to any person, entity, or circumstance, or is stayed or enjoined, that		No comparable provision in FPS.		Not applicable

	provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event the provision shall be severable from this subpart and shall not affect the remainder of the subpart				
§1910.509(a) Incorporation by Reference.	§ 1910.509 Incorporation by Reference. (a)(1) The material listed in this section is incorporated by reference into this subpart with the approval of the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. To enforce any edition other than that specified in this section, OSHA must publish a document in the Federal Register and the material must be available to the public. All approved material is available for inspection at any Regional Office of the Occupational Safety and Health Administration (OSHA), or at the OSHA Docket Office, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-3508, Washington, DC 20210; telephone: 202-693-2350 (TTY number: 877-889-5627). It is also available for inspection at the National Archives and Records Administration (NARA). For information on the availability of these standards at NARA, email fedreg.legal@nara.gov , or go to www.archives.gov/federal-register/cfr/ibr-locations.html . (2) The material is available from the sources listed in this section and as follows: (i) The material listed in paragraphs (b) and (c) of this section (CDC and EPA) is available at this permanent weblink hosted by OSHA: www.osha.gov/coronavirus/ets/ibr . (ii) The material listed in paragraph (d) of this section (ISEA) is available from the American National Standards Institute (ANSI), 25 West 43rd Street, 4th Floor, New York, NY 10036; telephone: 212-642-4900; fax: 212-398-0023; website: http://www.ansi.org .		Not applicable		
§1910.509(b) Centers for Disease Control and Prevention (CDC).	(b) Centers for Disease Control and Prevention (CDC). 1600 Clifton Road, Atlanta, GA 30329; websites: https://www.cdc.gov/ , https://www.cdc.gov/coronavirus/2019-ncov/communication/guidance.html , and https://www.cdc.gov/infectioncontrol/guidelines/ . (1) Cleaning and Disinfecting Guidance. COVID-19: Cleaning and Disinfecting Your Facility; Every Day and	16VAC25-220-10.E. Purpose, scope, and applicability.	E. To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard. An employer's actual compliance with a recommendation		See DOLI §40, FAQs 41, 42, 43 and 44 on CDC updates concerning cleaning and disinfecting. https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

	<p>When Someone is Sick, updated April 5, 2021, incorporation by reference (IBR) approved for § 1910.502(j). (2) COVID-19 Infection Prevention and Control Recommendations. COVID-19: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated February 23, 2021, IBR approved for §§ 1910.502(d) and (j). (3) Guidelines for Isolation Precautions. 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, updated July 2019, IBR approved for §§ 1910.502(e) and (f). (4) Guidelines for Environmental Infection Control. Guidelines for Environmental Infection Control in Health-Care Facilities, updated July 2019, IBR approved for § 1910.502(j). (5) Isolation Guidance. COVID-19: Isolation If You Are Sick; Separate yourself from others if you have COVID-19, updated February 18, 2021, IBR approved for § 1910.502(l). (6) Return to Work Healthcare Guidance. COVID-19: Return to Work Criteria for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance), updated February 16, 2021, IBR approved for § 1910.502(l).</p>		<p>contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 and COVID-19 related hazards or job tasks addressed by a provision of this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard. The Commissioner of Labor and Industry shall consult with the State Health Commissioner for advice and technical aid before making a determination related to compliance with CDC guidelines.</p>		
<p>§1910.509(c) U.S. Environmental Protection Agency (EPA):</p>	<p>(c) U.S. Environmental Protection Agency (EPA): 1200 Pennsylvania Avenue, NW, Washington, DC 20460; website: https://www.epa.gov/. (1) List N. Pesticide Registration List N: Disinfectants for Coronavirus (COVID19), updated April 9, 2021, IBR approved for § 1910.502(b). (2) [Reserved]</p>	<p>16VAC25-220-40.L.7. Mandatory requirements for all employers.</p>	<p>See: L. Sanitation and disinfecting. 7. Employers shall ensure that cleaning and disinfecting products are readily available to employees to accomplish the required cleaning and disinfecting. In addition, employers shall ensure use of only disinfecting chemicals and products indicated in the Environmental Protection Agency (EPA) List N for use against SARS-CoV-2, or non-EPA registered disinfectants that otherwise meet the EPA criteria for use against SARS-CoV-2.</p>		
<p>§1910.509(d) International Safety Equipment Association (ISEA):</p>	<p>(d) International Safety Equipment Association (ISEA): 1901 North Moore Street, Suite 808, Arlington, VA 22209; website: www.safetysafetyequipment.org (1) ANSI/ISEA Z87.1-2010, American National Standard for Occupational and Educational Personal Eye and Face Protection Devices, ANSI-approved April 13, 2010, IBR approved for § 1910.502(b). (2) ANSI/ISEA Z87.1-2015, American National Standard for Occupational and Educational Personal Eye and Face Protection Devices, ANSI-approved May 28, 2015, IBR approved for § 1910.502(b). (3) ANSI/ISEA Z87.1-2020, American National Standard for Occupational and Educational</p>		<p>Not applicable</p>		

	Personal Eye and Face Protection Devices, ANSI-approved March 11, 2020, IBR approved for § 1910.502(b).				
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