



USING THE OSHA EMERGENCY TEMPORARY STANDARD FOR COVID-19 TO PROTECT HEALTHCARE WORKERS

Writing Complaints and Preparing for an Inspection



A Union of Professionals

**AFT Nurses and
Health Professionals** ❤️

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The **American Federation of Teachers** is a union of professionals that champions fairness; democracy; economic opportunity; and high-quality public education, healthcare and public services for our students, their families and our communities. We are committed to advancing these principles through community engagement, organizing, collective bargaining and political activism, and especially through the work our members do.

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AFT members are facing unsafe working conditions because of COVID-19 and as a result of very poor staffing. Filing a complaint with the Occupational Safety and Health Administration is one thing that local unions can do to force improvements in their workplaces. This guidance can help you determine whether the employer has complied with the requirements of the Emergency Temporary Standard (ETS) for COVID-19. The complete standard is here: [COVID-19 Healthcare ETS | Occupational Safety and Health Administration \(osha.gov\)](#).

OSHA can also investigate employers for violations of other standards and for safety problems the staffing crisis has exacerbated. OSHA cannot cite the employer for poor staffing, but an OSHA investigation and potential citation will force the employer to address safety failures.

The ETS can also be used as a floor for bargaining. See [AFT resources on the COVID-19 coronavirus | American Federation of Teachers](#) and [OSHA Emergency Temporary Standard Webinar | AFT eLearning](#) or [AFT Nurses and Health Professionals Community | AFT eLearning](#) for more information on bargaining for stronger protections.



TABLE OF CONTENTS

Timing	1
Who Is Covered?	1
Who Is Not Covered?	1
Employers Must Make a Written Plan	2
Personal Protective Equipment	2
Facemasks	2
Respirators	2
The Mini-Respiratory Protection Program (1910.504)	3
Other Personal Protective Equipment	3
Aerosol-Generating Procedures on Patients with Suspected or Confirmed COVID-19	4
Physical Distancing and Barriers	4
Ventilation and Filtration	4
Cleaning and Disinfection	5
Health Screening	5
Employer Notification of Employee Exposure	5
Medical Removal (Quarantine)	5
Medical Removal Benefits	6
Return to Work for Infected Workers	6
Vaccination	6
Training	6
Anti-Retaliation	7
Record-Keeping	7
Reporting COVID-19 Fatalities and Hospitalizations to OSHA	7
Tips for Writing an OSHA ETS Complaint	8
Preparing for an Inspection	9





Timing

In effect from July 6 to Dec. 21, 2021. OSHA may extend the ETS by making it permanent.

Who Is Covered?

Healthcare facilities: workers in hospitals, nursing homes, assisted living facilities, emergency responders, home healthcare, and ambulatory care facilities where COVID-19 patients are treated. Workers in healthcare facilities embedded in non-healthcare settings (such as a school health suite, a prison health clinic) are covered, but not the rest of the workplace.

Who Is Not Covered?

Healthcare employers may exempt some settings if they meet these requirements:

Ambulatory healthcare facilities outside hospitals may be excluded if all nonemployees are screened and people with suspected or confirmed COVID-19 may not enter.

Well-defined ambulatory healthcare settings within hospitals may be excluded if all employees are fully vaccinated and all nonemployees are screened to prevent people with suspected or confirmed COVID-19 from entering.

Home healthcare settings may be exempted if all employees are fully vaccinated and all nonemployees are screened prior to entry and if people with suspected or confirmed COVID-19 are not present. The ETS does require home health employers to provide protections for employees entering private homes or other locations not controlled by the employer. This could include guaranteed access to respiratory protection or policies and procedures for withdrawing from the home if patients or others present have suspected or confirmed COVID-19.

Well-defined areas within hospitals and other facilities “where there is no reasonable expectation that any person with suspected or confirmed COVID-19 will be present” can be exempted from requirements for respirators and other personal protective equipment, distancing, and barriers if employees are fully vaccinated. Other parts of the ETS (training, record-keeping, employee notification, medical removal, etc.) are still required for these units.

Employers Must Make a Written Plan

Conduct a site-specific hazard assessment.

Develop and implement a written plan that addresses the hazards identified and minimizes the risk of transmission for each employee.

Seek input and involvement from nonmanagerial employees and their representatives.

Designate one or more knowledgeable people as safety coordinators to implement and monitor the plan.

Monitor the plan for effectiveness and update it as needed.

Include policies and procedures to determine employees' vaccination status.

Communicate and coordinate the plan with employers of subcontractors/vendors who are present in the workplace.

Limit and monitor points of entry. Screen and triage all patients and other nonemployees. Implement patient management strategies as per the Center for Disease Control and Prevention's "COVID-19 Infection Prevention and Control Recommendations," incorporated into the ETS.

Implement policies and procedures to adhere to Standard and Transmission-Based Precautions as required in the CDC's **Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007)**, incorporated into the ETS.

Information request

Ask for a copy of all past written plans and future updated versions. Review them to see if they include all the requirements.

Personal Protective Equipment

Face Masks

Employers must provide, and employees must wear, face masks in covered areas of the facility and when occupying a vehicle with others for work purposes.

Employees do not have to wear face masks in exempted areas of the facility; when alone in a room; when eating or drinking; if distanced by six feet or by a physical barrier; or when wearing a respirator.¹

There is a set of narrow exceptions that allow an employee to wear a face shield instead of a face mask:²

- If hazardous, such as in the case of extreme heat that would cause heat stress.
- For medical necessity or a disability protected by the Americans with Disabilities Act.
- Religious exemption under the Civil Rights Act.

Respirators

Employers must adhere to the requirements of the respiratory protection standard (1910.134) *when employees are exposed to persons with suspected or confirmed COVID-19 and when conducting aerosol-generating procedures (AGPs)*. Close contact is defined, but exposure is not.³

The respiratory protection standard requires:

- Medical evaluation because respirator use makes breathing difficult for people with heart and lung conditions.
- Annual fit testing and novel fit testing for any respirator model that is new for the wearer to ensure there is no leakage.
- Training on proper donning, doffing, and conducting seal checks.

The ETS allows employers to resort to the CDC's **Summary for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during Shortages** when supplies are limited. OSHA previously said in the National Emphasis Program that earlier shortages have been resolved, and employers requiring extended respirator use or reuse of N95s must provide evidence of good-faith efforts to obtain an adequate supply of respirators. The Food and Drug Administration has rescinded emergency use authorizations for decontamination of N95s.⁴

¹ Although OSHA permits employers to designate areas within facilities where universal masking is not required, healthcare facilities are likely to follow CDC guidance for universal indoor masking.

² Face shields cannot protect the wearer from aerosolized transmission, and any employee who cannot wear a facemask should be offered other accommodation, such as remote work.

³ "Close contact" means being within six 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 two days before the person felt sick (or, for asymptomatic people, two days prior to test specimen collection) until the time the person is isolated.

⁴ OSHA encourages employers to use (but does not require) reusable elastomeric respirators and powered air-purifying respirators (PAPRs) to avoid respirator shortages.



The Mini-Respiratory Protection Program (1910.504)

OSHA has created a new category of respirator use in the ETS. Employers must allow employees to wear a respirator instead of a face mask to enhance protection.⁵ Employees may use employer-provided respirators or wear their own. This program only applies to the COVID-19 ETS and no other hazards.

Employers' obligations under the Mini-Respiratory Protection Program (1910.504) are fewer than those required in the Respiratory Protection Standard (1910.134). The employer does not have to conduct medical evaluations or fit-testing under 1910.504. They must ensure that workers conduct seal tests.

The employer's only training responsibilities cover:

- Informing employees that a respirator that has not been fit tested is not as protective as a respirator that has been fit tested. A properly used respirator can offer more protection, and an improperly used respirator can be dangerous. The respirator should only be used as protection from COVID-19 and no other hazard.
- How to don, doff and conduct seal checks.
- How to care for and when to discard a respirator. Employees should read and follow the manufacturer's instructions on use and care.
- The respirator should only be used by one person. If respirators are reused, they should be stored in a paper bag for five days between uses and used no more than five times in total.

Other Personal Protective Equipment

Gloves, isolation gowns or equivalent protective clothing and eye protection are required for exposure and when conducting aerosol-generating procedures (AGPs) in accordance with Standard and Transmission-Based Precautions in healthcare settings in accordance with CDC's [Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings](#).

Information request

- Focus information requests on the last six months. OSHA will not currently investigate older issues.
- Request a copy of any written communications to staff on use of PPE. Ask members to share information and documentation on access to N95s and other PPE, including any extended use or reuse.
- Ask members who are in close contact with or conduct AGPs on patients with suspected or confirmed COVID-19 whether fit-testing has resumed for novel respirators. Are new staff being medically evaluated and fit-tested?
- Ask members using respirators under the Mini-Respiratory Protection Program if the requirements are being met.

⁵ An employee is required to wear a respirator in accordance with the Respiratory Protection Standard (1910.134) if they are in close contact with or conduct an AGP on a person with suspected or confirmed COVID-19. An employee is required to wear a face mask in non-exempted (covered) parts of the facility or while in an occupied vehicle for work purposes. The ETS does not require face masks in well-defined areas where COVID-19 is not reasonably expected, but CDC guidance advises universal masking in all indoor spaces.

Aerosol-Generating Procedures on Patients with Suspected or Confirmed COVID-19⁶

OSHA requires that AGPs be conducted in an existing airborne infection isolation room (AIIR) if one is available. The employer must limit the number of employees present to only those essential for care and procedural support. Employees must wear a fit-tested respirator,⁷ gown, eye protection and gloves. Room surfaces and equipment must be disinfected following the procedure.

Physical Distancing and Barriers

Six-foot distancing and barriers are not effective mitigations. SARS-CoV-2, the virus that causes COVID-19, is primarily spread through aerosol transmission. The viral particles are suspended in the air and do not fall to the floor within six feet as droplets from sneezes and coughs do. We have a growing body of scientific evidence to prove this.⁸ Although the CDC has acknowledged aerosol transmission of SARS-CoV-2, that agency continues to recommend distancing and barriers.



The ETS reflects CDC guidance. It includes requirements for six-foot distancing where feasible, such as in non-patient care areas. Where it is not feasible, the employer must ensure as much space as possible. At fixed work locations outside of patient-care

areas (registration desks, pharmacy, etc.) the employer must erect cleanable or disposable physical barriers where six-foot distancing is not feasible. Barriers must be sized to block face-to-face pathways between people.

These requirements are weak, but implementing the distancing requirements can result in room occupancy limits, use of telemedicine and remote work where feasible, which are effective controls.

Ventilation and Filtration

Ventilation and filtration are among the most important controls for reducing the risk of infection spread. Ventilation is using the HVAC (heating, ventilating and air conditioning) system to bring in fresh outdoor air on a regular basis. Filtration is moving indoor air through filters to avoid moving contaminated air into other areas.

Your facility may already be in compliance with the ASHRAE 170 standard for healthcare facilities, which is stronger than what the ETS requires.⁹ The current 170 standard requires MERV 14 filters to efficiently capture SARS-CoV-2 and other infectious disease particles.¹⁰ Non-patient care areas are covered by ASHRAE standards 62.1 and 62.2 for residential and non-residential buildings.

Unfortunately, the ETS is less stringent. Employers who own or control the HVAC systems must ensure that:

The HVAC system is used in accordance with the manufacturer's instructions and design specifications.

The amount of outside air circulated through the HVAC systems and the number of air changes per hour are maximized to the extent appropriate.

All air filters are rated MERV 13 or higher, if compatible with the HVAC system(s). If MERV-13 or higher filters are not compatible, employers must use filters with the highest compatible filtering efficiency.

All air filters are maintained and replaced as necessary to ensure proper performance.

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 system(s).

The employer must maintain and operate existing AIIRS in accordance with the manufacturer's design and construction criteria.

⁶ OSHA defines AGPs as the following 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

⁷ Respirator use during AGPs must meet the requirements of the Respiratory Protection standard, not the Mini-Respiratory Protection standard.

⁸ **Scientists Call on CDC to Set Air Standards for Workplaces, Now.** *New York Times* ([nytimes.com](https://www.nytimes.com))

—Tang, J.W., et al. Dismantling myths on the airborne transmission of severe acute respiratory syndrome coronavirus (SARS-CoV-2), *Journal of Hospital Infection*, <https://doi.org/10.1016/j.jhin.2020.12.022>.

—Meselson M. Droplets and Aerosols in the Transmission of SARS-CoV-2. *New England Journal of Medicine*. May 21, 2020;382(21):2063. doi: 10.1056/NEJMc2009324. Epub 2020 April 15. PMID: 32294374; PMCID:PMC7179963.

—Morawska L, Cao J. Airborne transmission of SARS-CoV-2: The world should face the reality. *Environ Int*. June 2020;139:105730. doi: 10.1016/j.envint.2020.105730. Epub 2020 April 10. PMID: 32294574; PMCID: PMC7151430.

⁹ ASHRAE, a professional association for HVAC engineers, sets consensus standards with the American Society for Health Care Engineering (ASHE) and the American National Standards Institute (ANSI). The standard is updated every few years, most recently in May 2021

¹⁰Minimum Efficiency Reporting Value (MERV) is a system to rate the effectiveness of filters.

Consider other methods for improving ventilation

recommended in the CDC's ventilation guidance in [Air | Background | Environmental Guidelines | Guidelines Library | Infection Control](#). The CDC also recommends the ASHRAE guidance www.ashrae.org/technical-resources/healthcare.

Information request

- What enhancements have been made to the HVAC system in response to COVID-19?
- What inspections and calibrations has the employer completed to increase ventilation and filtration?
- Is the employer following the ASHRAE 170 standard and/or ASHRAE's COVID-19 guidance?

Cleaning and Disinfection

OSHA requires employers to follow the CDC's standard practices in [Infection Control: Severe acute respiratory syndrome coronavirus 2 \(SARS-CoV-2\)](#) and [Cleaning and Disinfecting Your Facility](#) in patient care areas, resident rooms, and for medical devices and equipment. In all other areas, high-touch surfaces and equipment should be cleaned at least once a day, following manufacturers' instructions for application of cleaners.

When an infected person has been in the workplace within the last 24 hours, clean and disinfect areas, materials, and equipment likely to have been contaminated in accordance with CDC's cleaning and disinfecting guidance.

Health Screening

Employee screening must be conducted before each workday and each shift. If the employer conducts testing as part of the screening system, the employer provides the tests at no cost to the employee.

Employees must promptly notify the employer if they test positive; have been told by a licensed healthcare provider they may be infected; experience a sudden loss of taste and/or smell with no other explanation, or have both fever (≥ 100.4 degrees F) and new unexplained coughing associated with shortness of breath.

Employer Notification of Employee Exposure

The employer must give notification of exposure (notification must not include any employee's name, contact information or occupation) within 24 hours to the following people:

A person not wearing a respirator and required PPE who was in close contact. Notification must include the dates of close contact.

Employees not wearing a respirator and required PPE present in the same well-defined area (such as a floor) where an infected person was present must be notified. The potential transmission period runs from two days before the person felt sick (or, for asymptomatic people, two days prior to test specimen collection) until the time the person is isolated. The notification must specify the dates the person with COVID-19 was in the workplace during the potential transmission period.

Other employers whose employees (including vendors, agency staff) who were present and were not wearing a respirator and required PPE during the transmission period.

Notification exception: Employers do not have to notify employees in settings where services are normally provided to patients with suspected or confirmed COVID-19, such as emergency rooms, urgent care facilities, testing sites, COVID-19 units, regardless of whether the employee was wearing a respirator.

Medical Removal (Quarantine)

An employee who has been confirmed positive for COVID-19 must be removed from work until they meet return-to-work criteria.

People exposed through close contact who do not have symptoms and are fully vaccinated or have recovered from COVID-19 within 90 days are not subject to medical removal. Otherwise, the employer must remove the person for 14 days or for seven days if a PCR test comes back negative. The test must be taken at least five days post-exposure.

An employee who is suspected of infection must be removed until they meet return-to-work criteria or a PCR test comes back negative. If any employee refuses to take the test, they must remain removed, but the employer is not obligated to provide medical removal protection benefits.

The employer may assign remote work if it is available to employees who are on medical removal. They must receive their usual pay and benefits.

Medical Removal Benefits

Employees removed from work must receive their benefits and regular pay up to \$1,400 per week until their return to work. Employers with fewer than 500 employees may reduce the amount to two-thirds of regular pay, up to \$200 per day, (which OSHA assumes means \$1,000 per week) starting in the third week of medical removal.

The employer's payment obligation is reduced by the amount of compensation the employee receives from any other source, including sick days, administrative leave or any other additional source of income made possible by the medical removal.

[See **1910.502(l)(5)(iv)**.]

The employee must not suffer adverse action due to the medical removal and must maintain all rights and benefits, including former job status.

Return to Work for Infected Workers

The ETS requires the employer to make return-to-work decisions based either on guidance from a licensed healthcare provider or the CDC's **Interim Guidance on Duration of Isolation and Precautions for Adults with COVID-19** and **Return-to-Work Criteria for Healthcare Workers**, giving employers flexibility. The guidance states that decisions should be made in the context of local circumstances and be based on symptoms rather than positive test results because PCR tests continue to show evidence of viral shedding past the infectious period.

Under this guidance, return to work should depend on the severity of the employee's illness and if he or she is severely immunocompromised. Employees with mild to moderate symptoms could return 10 days after symptoms started, at least 24 hours after the last fever without the use of fever-reducing medications, and symptoms improved. Workers who remain asymptomatic could return to work 10 days after their first positive test.

The ETS also allows employers to follow the CDC's **Strategies to Mitigate Healthcare Personnel Staffing Shortages** in times of staffing shortages, but only as a last resort for patient safety. Employers must first attempt specific amelioration strategies, patients must be notified that workers have returned while they are potentially infectious and workers are wearing additional PPE at all times.



Vaccination

The employer must support COVID-19 vaccination for employees by providing paid sick or administrative leave. The employer must have a system for tracking employees' vaccination status and should follow Equal Employment Opportunity Commission guidance for those with medical or religious exemptions.

Training

Each employee must receive training in a language and at a literacy level he or she understands from a person knowledgeable in the subject matter as it relates to job duties. The employee must have the opportunity for questions and answers. Training that was conducted prior to the release of the ETS counts. Training must cover:

How the disease is transmitted, including pre-symptomatic and asymptomatic transmission, reducing spread through hand hygiene and masking, symptoms, and when to seek medical attention. Employees should know the identities of the safety coordinators.

The employer's policies and procedures for patient screening and management: high-risk work tasks and situations; infection control policies and procedures applicable to the employee's job; cleaning and disinfection; policies and procedures for multi-employer settings, including use of common areas and shared equipment; and cleaning and disinfection procedures.

Use of PPE: limitations; how to properly put on and take off PPE; how to care for, store, clean, maintain and dispose of PPE, as well as any modifications to these procedures needed to address COVID-19 when PPE is worn for protection from other hazards.



The employer's policies and procedures for workers' health: screening, notification, medical removal, return to work, sick leave, any COVID-19 benefits or supportive policies. Employees must be told how they can access copies of the ETS, any employer-specific policies and procedures, and the COVID-19 plan.

Additional training must be provided when changes occur that affect the employee's risk of infection (such as new job tasks); policies or procedures are changed; or there is indication the employee has not retained necessary knowledge or skill.

Anti-Retaliation

The employer is prohibited from discharging or discriminating against any employee for exercising their right to the protections required by the standard or for engaging in actions required by the standard. Employees must be notified of this right. Employees are also protected from retaliation for filing a safety and health complaint under Section 11(c) of the Occupational Safety and Health Act. Requirements must be implemented at no cost to employees, except for any cost of employee self-monitoring.

Record-Keeping

Employers with more than 10 employees must retain all versions of the COVID-19 plan and keep a log of all cases of employee COVID-19 infection, regardless of whether the infection was work-related. The log must contain the employee's name, one form of contact information, work location, the last date at work, the date of the positive test or diagnosis, and the date one or more symptoms appeared.

Employers must record cases within 24 hours of learning of them. The log must be maintained as a confidential medical record intended to support contact tracing. The log must not be disclosed except as required by the ETS or by other federal law. The employer must provide records for examination and copying by the end of the next business day, including:

All versions of the written COVID-19 plan to employees, their personal representatives, or their authorized representatives.

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

A copy of the COVID-19 log that excludes names, contact information, and occupation, but includes for each case: locations, the last day in the workplace before medical removal, the date of the positive test or diagnosis, date of symptom onset. Employees, their personal representatives, and their authorized representatives are entitled to this copy of the log under the ETS. Employers must also continue to record work-related COVID-19 cases in the OSHA 300 log, 300A form and 301 form as required by the record-keeping standard.

Reporting COVID-19 Fatalities and Hospitalizations to OSHA

The employer must report to OSHA:

Each work-related COVID-19 fatality within eight hours of the employer learning of the fatality.

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

Information request

Ask for copies of the COVID-19 log and the OSHA 300 log on a regular basis and compare the logs. Names should not be redacted on the OSHA 300 log unless the worker has specifically requested to have his or her name redacted. It is important that the employer record all work-related cases on the OSHA 300 log for employees who will need to claim workers' compensation, particularly if they experience long COVID-19. Unless there is a state workplace presumption law, the employer is likely to undercount work-related cases.



Tips for Writing an OSHA ETS Complaint

If you are pursuing a complaint, it should be written; complaints reported over the phone are not likely to result in an on-site inspection. It is more effective for a local to file a comprehensive written complaint on behalf of all at-risk workers in an affected facility. You can use the OSHA complaint form as a guide, but you're not required to use it.

Please note that OSHA is not currently investigating hazards that occurred more than six months ago. Some of the information you gather will date back to the beginning of the pandemic, such as the employer's original written COVID-19 response plan and subsequent revisions, as well as other written policies and procedures. You should have that information, but OSHA will only act on hazards happening in the last six months and if they are ongoing.

However, OSHA will investigate older record-keeping compliance failures. Inform OSHA if the employer has not recorded employees' work-related COVID-19 cases, especially those that resulted in hospitalization or death. Work-relatedness is hard to prove, but if many employees have been infected and that is not reflected on the OSHA 300 log, OSHA may cite the employer. OSHA is likely to cite the employer for failure to record hospitalizations and fatalities.

Here are some recommendations for preparing a strong complaint:

Secure the employer's written COVID-19 plan and compare with the list of ETS requirements in this document or see the ETS text at [COVID-19 Healthcare ETS | Occupational Safety and Health Administration](#).

Assess members' accounts of the workplace reality to determine potential violations of the emergency temporary standard. Interview workers to create specific descriptions of exposures, units and job titles, and lags in protection—as much detail as possible will strengthen the complaint.

Gather as much documentation (employer memos and messages, photos of message boards, etc.) as possible.

Compile and include descriptions of any failures of the employer to follow its own policies and procedures. Unfortunately, the employer is given substantial flexibility in many domains, including medical removal and return-to-work requirements. Employers who fail to notify workers who have been exposed may be cited, but they are not required to notify workers in areas where COVID-19 patients can be reasonably expected. OSHA is likely to target a lack of compliance on respiratory protection and record-keeping because those requirements are clear.

Provide the name and address of the facility. Name the CEO and the lead safety coordinator.

Identify the union and include how many employees and job titles the union represents.

Include information about any non-COVID-19 health and safety hazards or incidents, such as needlesticks, ergonomic injuries, workplace violence,

or slips, trip and falls. Conditions are likely to have worsened, and OSHA must investigate issues you include.

Do not assume OSHA is familiar with the employer or with healthcare generally. Spell out acronyms and identify department names.

Attach the documentation as appendices, keeping the information organized for easy reference.

If a leader is the signer, be sure to provide the individual's contact information and your name and contact information as the person following up. Ask to be included in all correspondence and the opening conference. Keep track of your correspondence with OSHA.

Identify a leader, steward or trusted member who can be available to attend an unannounced inspection—at least one for every shift—if a compliance officer shows up to inspect the facility. You will not be told in advance. The compliance officer will ask the employer to notify the union that an inspection is about to begin, but there will not be much notice. The start of the inspection is the opening conference.

The complaint can be sent to OSHA by mail, email, fax or online submission. We recommend sending it first by email with a "read receipt," followed up with a mailed copy. Attach documentation that has been organized to correspond to the problems listed. See more on filing at [File a Complaint | Occupational Safety and Health Administration](#).

Preparing for an Inspection

Make a list of those who are willing to speak to an OSHA compliance officer if OSHA investigates, including contact information and good times to reach them. Making it easy for the compliance officer to speak to workers is important.

If you have a list of all the members who have been infected in the last six months, include it. Ask the compliance officer to compare your list to the employer's COVID-19 log and the OSHA 300 log. The OSHA 300 log should also include the number of days people have been out.

Although the ETS does not provide as many clear enforceable requirements as we had hoped, knowing what the standard requires puts the employer on notice. **Writing a complaint can be a union-building activity. Getting OSHA to investigate can be counted as a victory even if OSHA does not issue a citation or only issues a warning letter.**

For more information or assistance, please contact Sara Markle-Elder at smarkle@aft.org within the Health Issues Department at the AFT.





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