

**April 22, 2022**

**Comments on the Occupational Safety and Health Administration’s Standard for  
Occupational Exposure to COVID-19 in Healthcare Settings  
Docket No. OSHA–2020–0004**

Public Citizen, a consumer and worker advocacy organization with more than 500,000 members and supporters nationwide, submits these comments regarding the Occupational Safety and Health Administration’s (OSHA’s) notice “Occupational Exposure to COVID-19 in Healthcare Settings,” which was published in the *Federal Register* on March 23, 2022 (Docket No. OSHA–2020–0004).<sup>1</sup>

On June 21, 2021, OSHA published 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 (“COVID-19 Healthcare Settings ETS”).<sup>2</sup> Although the ETS took effect immediately, OSHA requested comments on whether it should become permanent, as well as on all other aspects of the ETS. The agency is now preparing to promulgate a final standard and is seeking public comment on certain specific topics and questions for development of the final standard.

Public Citizen strongly supports OSHA’s plan to issue a final standard to protect healthcare and healthcare support service workers from occupational exposure to COVID-19. We offer the following comments addressing several of the topics and questions raised in the agency’s March 23, 2022, *Federal Register* notice regarding potential changes in the final standard from the ETS.

**A.2—Additional Flexibility for Employers**

The COVID-19 Healthcare Settings ETS was designed to protect workers from the spread of a deadly pandemic. While COVID-19 cases have receded, the pandemic continues to take lives as new variants and subvariants of SARS-CoV-2, the virus that causes COVID-19, ebb and flow. The burden on the general public, workers and employers to guard against transmission of SARS-CoV-2 has been high. Some employers have raised concerns that the requirements of the COVID-19 Healthcare Settings ETS have been overly burdensome and have asked for more flexibility in workplace procedures.

Although it may be appropriate for certain provisions of the final standard to be restated as broader requirements without the level of detail included in the ETS, some provisions should remain detailed and prescriptive. Most importantly, given the White House’s recent acknowledgment that aerosol transmission of SARS-CoV-2 is the “most common way COVID-

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<sup>1</sup> 87 Fed. Reg. 16426

<sup>2</sup> 86 Fed. Reg. 32376; 29 C.F.R. 1910

19 is transmitted from one person to another,”<sup>3</sup> it is imperative that the final standard prescribe detailed requirements for ensuring appropriate facility ventilation and use of respirators approved by the National Institute for Occupational Safety and Health (NIOSH) in order to protect healthcare and healthcare support service workers from SARS-CoV-2 aerosols.

According to the Centers for Disease Control and Prevention (CDC)<sup>4</sup> aerosol transmission of SARS-CoV-2 resulting in COVID-19 has been repeatedly documented under certain preventable circumstances.<sup>5</sup> These transmission events typically involved the presence of an infected individual exhaling virus indoors for an extended time, leading to virus concentrations in the air space sufficient to transmit infections to people more than six feet away, and in some cases to people who had passed through that space soon after the infectious person left.<sup>6</sup>

In order to provide essential facility ventilation consistent with current research and recommendations, the existing ventilation requirements<sup>7</sup> should be amended to include maximal use of exhaust fans in restrooms and kitchens, portable HEPA filtration systems in high-risk areas, and use of ultraviolet germicidal irradiation as indicated in CDC guidance on ventilation in buildings.<sup>8</sup> Additionally, the existing requirement for air circulation through HVAC systems<sup>9</sup> should be modified to require air changes a minimum of five times per hour, consistent with research showing a 50% reduction in the risk of viral transmission with this air change rate.<sup>10</sup> It

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<sup>3</sup> The White House. Let’s clear the air on COVID-19. March 23, 2022. <https://www.whitehouse.gov/ostp/news-updates/2022/03/23/lets-clear-the-air-on-covid/>. Accessed April 22, 2022.

<sup>4</sup> Centers for Disease Control and Prevention. COVID-19. Scientific brief: SARS-CoV1 transmission. May 7, 2021. <https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html>. Accessed April 22, 2022.

<sup>5</sup> See, e.g., Brlek A, Vidovic S, Vuzem S, et al. Possible indirect transmission of COVID-19 at a squash court, Slovenia, March 2020: case report. *Epidemiol Infect.* 2020 June 19;148:e120; Cai J, Sun W, Huang J, et al. Indirect virus transmission in cluster of COVID-19 cases, Wenzhou, China, 2020. *Emerg Infect Dis.* 2020;26(6):1343-1345; Shen Y, Li C, Dong H, et al. Community outbreak investigation of SARS-CoV-2 transmission among bus riders in eastern China. *JAMA Intern Med.* 2020;180(12):1665-1671; Groves LM, Usagawa L, Elm J, et al. Community transmission of SARS-CoV-2 at three fitness facilities — Hawaii, June–July 2020. *MMWR Morb Mortal Wkly Rep.* 2021;70(9):316–320; Hamner L, Dubbel P, Capron I, et al. High SARS-CoV-2 attack rate following exposure at a choir practice – Skagit County, Washington, March 2020. *MMWR Morb Mortal Wkly Rep.* May 15 2020;69(19):606-610; Lendacki FR, Teran RA, Gretsches S, et al. COVID-19 outbreak among attendees of an exercise facility — Chicago, Illinois, August–September 2020. *MMWR Morb Mortal Wkly Rep.* 2021;70(9):321-325; Li Y, Qian H, Hang J, et al. Probable airborne transmission of SARS-CoV-2 in a poorly ventilated restaurant. *Build Environ.* 2021 June;196:107788; Katelaris AL, Wells J, Clark P, et al. Epidemiologic evidence for airborne transmission of SARS-CoV-2 during church singing, Australia, 2020. *Emerg Infect Dis.* 2021;27(6):1677-1680; Charlotte N. High rate of SARS-CoV-2 transmission due to choir practice in France at the beginning of the COVID-19 pandemic. *J Voice.* 2020 Dec 23;S0892-1997(20)30452-5; Hwang SE, Chang JH, Oh B, et al. Possible aerosol transmission of COVID-19 associated with an outbreak in an apartment in Seoul, South Korea, 2020. *Int J Infect Dis.* 2021 Mar;104:73-76.

<sup>6</sup> Centers for Disease Control and Prevention. COVID-19. Scientific brief: SARS-CoV1 transmission. May 7, 2021. <https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html>. Accessed April 22, 2022.

<sup>7</sup> 29 C.F.R. 1910.502(k)

<sup>8</sup> Centers for Disease Control and Prevention. Ventilation in building, <https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html>. Accessed April 22, 2022.

<sup>9</sup> 29 C.F.R. 1910.502(k)(1)(ii)

<sup>10</sup> Rothamer, D.A., et al. Strategies to minimize SARS-CoV-2 transmission in classroom settings: combined impacts of ventilation and mask effective filtration efficiency. *Science and Technology for the Built Environment*, 27:9,

is also essential for the final standard to prescribe detailed requirements ensuring provision and use of NIOSH-approved N95 or equivalent or higher-level respirators (and other personal protective equipment) in healthcare settings when there is a possibility that people with COVID-19 or asymptomatic SARS-CoV-2 infection are present.

### **A.3—Removal of Scope Exemptions (e.g., ambulatory care facilities where COVID-19 patients are screened out; home healthcare)**

The burden of proof for promulgating a permanent OSHA standard under the Occupational Safety and Health Act of 1970 (OSH Act)<sup>11</sup> is different than the burden of proof used for issuance of an emergency temporary standard. The details of the COVID-19 Healthcare Settings ETS were crafted using a finding of “grave danger” from SARS-CoV-2 and that the ETS was “necessary to protect employees from such danger” as required under Section 6(c) of the OSH Act.<sup>12</sup> As such, the ETS was limited in scope to settings with the most acute risk of exposure to the virus, exempting facilities where the risk was not as profound. Under the OSH Act, the issuance of a permanent standard requires only a finding of “significant risk” from the hazard and that the standard can substantially lessen or eliminate the hazard.<sup>13</sup> This lowered burden allows OSHA to craft a final standard to reduce exposure to SARS-CoV-2 in a broader range of healthcare settings.

Of the healthcare or healthcare support service settings that were exempted from the scope of coverage by the COVID-19 Healthcare Settings ETS, Public Citizen recommends removing the following scope exemptions from the final standard:

- (1) 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;<sup>14</sup>
- (2) 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;<sup>15</sup> and
- (3) 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.<sup>16</sup>

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1181-1203 (2021). <https://www.tandfonline.com/doi/full/10.1080/23744731.2021.1944665>; de Oliveira, P.M., et al. Evolution of spray and aerosol from respiratory releases: theoretical estimates for insight on viral transmission. *Proceedings of the Royal Society A* 477: 20200584 (2021). <https://doi.org/10.1098/rspa.2020.0584>.

<sup>11</sup> 29 U.S.C. 651 *et. seq.*

<sup>12</sup> 29 U.S.C. 655(c)(1)

<sup>13</sup> 29 U.S.C. 655(b). *See, also, 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); *Indus. Union Dep't v. Amer. Petroleum*, 448 U.S. 607 (1980).

<sup>14</sup> 29 C.F.R. 1910.502(a)(2)(iii)

<sup>15</sup> 29 C.F.R. 1910.502(a)(2)(iv)

<sup>16</sup> 29 C.F.R. 1910.502(a)(2)(v)

We also recommend that the scope exemption for the dispensing of prescriptions by pharmacists in retail settings<sup>17</sup> be modified to require coverage of pharmacists who engage in activities that involve more direct close contact with patients, such as administering vaccines.

Healthcare and healthcare support services workers in the above (and other) healthcare settings will continue to have significant risk of exposure to COVID-19 for the foreseeable future, and the level of risk is likely to fluctuate over time. Screening procedures for non-employees in non-hospital ambulatory care, well-defined hospital ambulatory settings, and home healthcare will not sufficiently mitigate the risk of exposure to COVID-19 given that individuals with infections caused by the highly transmissible SARS-CoV-2 variants, such as the Omicron variant, can be completely asymptomatic and easily transmit the virus to others. Moreover, fully vaccinated individuals often develop breakthrough infections due to the Omicron variant and future variants may be more likely to escape vaccine- or infection-induced immunity.

As Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases, and colleagues explained in a commentary published online in the *Journal of Infectious Diseases* on March 31, 2022, herd immunity against SARS-CoV-2 is likely “an unattainable goal.”<sup>18</sup> Obstacles to herd immunity that they identified include the following:

- The virus’ ability to continually mutate to new variants that can escape immunity derived from infections and vaccines;
- Asymptomatic virus transmission, which impedes public health control strategies;
- The failure of SARS-CoV-2, unlike certain other viruses such as smallpox, measles, and rubella, to substantially activate the systemic immune system;
- The inability of prior infection or vaccination to provide durable immune protection against reinfection or breakthrough infection, respectively;
- Suboptimal vaccination coverage in the population; and
- The lack of implementation of or adherence to non-pharmacologic public health interventions known to be effective.

Moreover, as Dr. Sarah Cobey and other scientists who study viral evolution explained in a March 28, 2022, opinion piece published in the *New York Times*, SARS-CoV-2 has significant capacity for developing additional mutations that would alter the antigens targeted by currently available COVID-19 vaccines and the natural immune response to infection.<sup>19</sup> Future mutations could either (a) make the virus more transmissible or more virulent than the widely circulating Omicron variant (and subvariants), or (b) render currently available COVID-19 vaccines less effective. Importantly, as an increasing proportion of the world population develops antibodies

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<sup>17</sup> 29 C.F.R 1910.502(a)(2)(ii)

<sup>18</sup> Morens DM, Folkers GK, Fauci AS. The concept of classical herd immunity may not apply to COVID-19. *J Infect Dis*. 2022 Mar 31;jiac109. doi: 10.1093/infdis/jiac109. Online ahead of print.

<sup>19</sup> Cobey S, Bloom J, Starr T, Lash N. We study virus evolution. Here’s where we think the coronavirus is going. *The New York Times*. March 28, 2022. <https://www.nytimes.com/interactive/2022/03/28/opinion/coronavirus-mutation-future.html>. Accessed April 22, 2022.

and other immune responses to SARS-CoV-2, there will be increasing evolutionary selective pressure for mutated variants that escape the immune protection afforded by the currently available COVID-19 vaccines or natural immunity. Cobey and colleagues concluded that they “expect SARS-CoV-2 will continue to cause new epidemics,” perhaps on a seasonal basis, as occurs with influenza.

### A.5.1—Booster Doses

For several reasons, any requirements under the final standard that take into account vaccination status of individuals must be based on the concept of “up to date” vaccination status as determined by the federal Advisory Committee on Immunization Practices (ACIP) and CDC, not the concept of “fully vaccinated” as was defined in OSHA’s COVID-19 Healthcare Settings ETS. First, there is extensive evidence of waning immune protection against symptomatic COVID-19, including against infection due to the Delta and Omicron SARS-CoV-2 variants, in individuals who had completed their primary COVID-19 vaccine series.<sup>20</sup> Second, research demonstrated that a single booster dose of the COVID-19 vaccines administered after completion of a primary COVID-19 vaccine series provided enhanced protection against symptomatic disease caused by the Omicron variant and against severe illness and death due to COVID-19 for all adults.<sup>21</sup> Additional research has shown that a second booster dose of the COVID-19 vaccines administered four or more months after the first booster dose provided further protection against symptomatic COVID-19 and severe COVID-19 for adults 60 years of age and older.<sup>22</sup> Third, experts in viral evolution predict that reformulated COVID-19 vaccines eventually may be needed to prevent severe COVID-19 due to new SARS-CoV-2 variants or subvariants that

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<sup>20</sup> Johnson AG, Amin AB, Ali AR, et al. COVID-19 incidence and death rates among unvaccinated and fully vaccinated adults with and without booster doses during periods of Delta and Omicron variant emergence — 25 U.S. jurisdictions, April 4–December 25, 2021. *MMWR Morb Mortal Wkly Rep.* 2022 Jan 28;71(4):132-138; Thompson MG, Natarajan K, Irving SA, et al. Effectiveness of a third dose of mRNA vaccines against COVID-19-associated emergency department and urgent care encounters and hospitalizations among adults during periods of Delta and Omicron variant predominance - VISION Network, 10 States, August 2021-January 2022. *MMWR Morb Mortal Wkly Rep.* 2022 Jan 21;71(4):139-145; Ferdinands JM, Rao S, Dixon BE, et al. Waning 2-dose and 3-dose effectiveness of mRNA vaccines against COVID-19-associated emergency department and urgent care encounters and hospitalizations among adults during periods of Delta and Omicron variant predominance – VISION Network, 10 States, August 2021-January 2022. *MMWR Morb Mortal Wkly Rep.* 2022 Feb 18;71(7):255-263; Andrews N, Stowe J, Kirsebom F, et al. Covid-19 vaccine effectiveness against the Omicron (B.1.1.529) variant. *N Engl J Med.* 2022 Mar 2;NEJMoa2119451. doi: 10.1056/NEJMoa2119451. Online ahead of print.; Centers for Disease Control and Prevention. COVID data tracker: COVID-19 vaccine effectiveness. <https://covid.cdc.gov/covid-data-tracker/#vaccine-effectiveness>. Accessed April 1, 2022.; Hall V, Foulkes S, Insalata F, et al. Protection against SARS-CoV-2 after Covid-19 vaccination and previous infection. *N Engl J Med.* 2022;386(13):1207-1220.

<sup>21</sup> Bar-On YM, Goldberg Y, Mandel M, et al. Protection of BNT162b2 vaccine booster against Covid-19 in Israel. *N Engl J Med.* 2021;385(15):1393-1400; Bar-On YM, Goldberg Y, Mandel M, et al. Protection against Covid-19 by BNT162b2 booster across age groups. *N Engl J Med.* 2021;385:2421-2430; Johnson AG, Amin AB, Ali AR, et al. COVID-19 incidence and death rates among unvaccinated and fully vaccinated adults with and without booster doses during periods of Delta and Omicron variant emergence — 25 U.S. jurisdictions, April 4–December 25, 2021. *MMWR Morb Mortal Wkly Rep.* 2022 Jan 28;71(4):132-138.

<sup>22</sup> Magen O, Waxman JG, Makov-Assif M, et al. Fourth dose of BNT162b2 mRNA Covid-19 vaccine in a nationwide setting. *N Engl J Med.* 2022 Apr 13. doi: 10.1056/NEJMoa2201688. Online ahead of print.

escape the immune protection provided by the currently available COVID-19 vaccines.<sup>23</sup> CDC replaced the earlier concept of “fully vaccinated” with “up to date” vaccination to address the shifting recommendations. In order to ensure workers receive maximal protection as the virus mutates, the permanent COVID-19 Healthcare Settings rule should follow suit.

### **A.5.2—Employer Support of Employee Vaccination**

Given the safety, efficacy, and substantial benefits of COVID-19 vaccinations, OSHA’s final standard should include employer support for employees who wish to stay up to date on vaccination and boosters in accordance with the ACIP and CDC recommendations. Such requirements should include paid time up to four hours, including travel time, for employees to receive any recommended dose of a COVID-19 vaccine necessary to stay up to date and paid sick leave for any time needed to recover from vaccine side effects. Such requirements should be maintained for employees of all healthcare and healthcare support settings, including those currently covered by the Centers for Medicare and Medicaid Services (CMS) Omnibus COVID-19 Health Care Staff Vaccination interim final rule (“CMS Health Care Staff Vaccination Rule”).<sup>24</sup> This is essential to maintain health and safety protections for all workers.

Importantly, The CMS and OSHA rules were crafted for different purposes and have distinct requirements. The purpose of the CMS rule is to protect “the health and safety of individuals to whom care and services are furnished” from COVID-19,<sup>25</sup> whereas the purpose of the OSHA rule is to “protect[] workers from COVID-19.”<sup>26</sup> The CMS rule requires workers in CMS-regulated healthcare settings to be fully vaccinated, whereas the OSHA rule requires all covered healthcare employers to provide reasonable time and paid leave for employees to get vaccinated and recover from side effects.<sup>27</sup>

There is no basis to differentiate workers in healthcare settings regulated by CMS from those in healthcare settings not regulated by CMS. The need for protection from COVID-19 transmission is the same at both. The broad applicability of the COVID-19 Healthcare Settings ETS is not in conflict with the CMS Health Care Staff Vaccination Rule. Indeed CMS has stated that the CMS Health Care Staff Vaccination Rule is “[c]omplementary to the OSHA ETS.”<sup>28</sup> However, to ensure clarity and consistency the final OSHA standard must state that where the CMS rule requires more employee support than required under the OSHA rule, the CMS rule shall apply.

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<sup>23</sup> Cobey S, Bloom J, Starr T, Lash N. We study virus evolution. Here’s where we think the coronavirus is going. *The New York Times*. March 28, 2022. <https://www.nytimes.com/interactive/2022/03/28/opinion/coronavirus-mutation-future.html>. Accessed April 22, 2022.

<sup>24</sup> Medicare and Medicaid Programs; Omnibus COVID-19 health care staff vaccination, 86 Fed. Reg. 61555-61627.

<sup>25</sup> 86 Fed. Reg. 61561- amending 42 C.F.R. 416, 418, 441, 460, 482, 483, 484, 485, 486, 491 and 494.

<sup>26</sup> Statement on the status of the OSHA COVID-19 Healthcare ETS, OSHA (Dec. 27, 2021), [osha.gov/coronavirus/ets](https://www.osha.gov/coronavirus/ets) (accessed 4/19/2022).

<sup>27</sup> 29 C.F.R 1910.502(m)

<sup>28</sup> Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination, 86 Fed. Reg. 61561.

### **A.5.3—Requirements for Vaccinated Workers**

OSHA is considering relaxing or eliminating some of the COVID-19 Healthcare Settings ETS workplace protection requirements for vaccinated workers or when there is a high vaccination rate of workers and/or the general community. Specifically, OSHA has asked for comments on relaxing requirements for masking, barriers, physical distancing, and exposure notification for vaccinated employees. Similarly, comments are requested on whether requirements should be relaxed in healthcare settings where a high percentage of the staff has been vaccinated.

Public Citizen opposes any relaxation or elimination of these important workplace protections, regardless of vaccination status or vaccination rate.

As noted in our comments regarding issue A.3 and A.5.1, workers will remain at significant risk of COVID-19 exposure for the foreseeable future and vaccination will not sufficiently protect workers. Not only do breakthrough infections often occur in vaccinated individuals, but it is, as yet, unknown how long the vaccines remain effective and when additional booster doses are needed. Additionally, the current vaccines may be less effective against new COVID-19 variants and subvariants expected in the future. With new virus variants and subvariants expected to be more transmissible and potentially more virulent, it is essential to provide workers with multiple forms of protection — not just vaccination. The final COVID-19 Healthcare Settings standard therefore should not relax requirements for masking, barriers, or physical distancing for vaccinated workers in areas of healthcare settings when there is a possibility that people with COVID-19 or asymptomatic SARS-CoV-2 infection are present. Nor should OSHA relax any of these worker protection requirements in healthcare settings where a high percentage of staff is vaccinated.

For the same reasons, OSHA should not relax the requirements for exposure notification for vaccinated employees. The COVID-19 Healthcare Settings ETS requires employers to notify, within 24 hours, workers who were not wearing respirators and other required personal protection equipment (PPE) if they have been in close contact with someone who is COVID-19 positive.<sup>29</sup> Employers must also notify employees who were not wearing a respirator and other required PPE if they worked in a well-defined portion of a workplace during the transmission period of someone with COVID-19.<sup>30</sup> Employers must notify other employers whose employees were exposed in the healthcare setting under the same circumstances.<sup>31</sup> These notifications are critical to the health of workers as they allow workers, regardless of vaccination status, to take important steps to protect themselves and others.

The CDC guidelines on quarantine and isolation currently recommend the following for individuals who were exposed to COVID-19 and are up to date on COVID-19 vaccinations:

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<sup>29</sup> 29 C.F.R. 1910.502(l)(3)(i)(A)

<sup>30</sup> 29 C.F.R. 1910.502(l)(3)(i)(B)

<sup>31</sup> 29 C.F.R. 1910.502(l)(3)(i)(C)

- Undergoing COVID-19 testing at least five days after their last close contact with someone with COVID-19;
- Watching for symptoms until 10 days after they last had close contact with someone with COVID-19;
- If symptoms develop, going into isolation immediately and remaining in isolation until knowing test results ;
- Wearing a well-fitting mask for ten full days after they were exposed to COVID-19 any time they are around others inside their home or in public and avoiding places where they are unable to wear a well-fitting mask;
- Taking certain precautions if traveling or planning to travel, including not traveling if they are waiting for results of a COVID-19 test; and
- Avoiding being around people who are more likely to get very sick from COVID-19.<sup>32</sup>

Adherence to such recommendations requires individual knowledge of COVID-19 exposure and necessitates appropriate exposure notification procedures for both vaccinated and unvaccinated employees.

#### **A.6—Limited Coverage of Construction Activities in Healthcare Settings**

The COVID-19 Healthcare Settings ETS did not expressly include employers engaging in construction work in covered healthcare settings. OSHA’s final standard should impose the same protections for workers engaged in construction work inside hospitals or other health care facilities as for workers engaged in maintenance or custodial tasks in the same facility. The only exception should be limited to those instances when construction work occurs in isolated wings or other spaces where construction employees would not be exposed to patients or other staff.

#### **A.7—Recordkeeping and Reporting: New Cap for COVID-19 Log Retention Period**

The requirements for recordkeeping and reporting under OSHA regulations at 29 C.F.R. 1910.502(q) and (r), respectively, should be maintained in the final standard. The record retention period should for the COVID-19 log required under OSHA regulations at 29 C.F.R. 1910.502(q) should be 30 years after the last entry in the log.

COVID-19 logs under 29 C.F.R. 1910.502(q)(2)(ii)(B) are to be “maintained as though it is a confidential medical record.” Under 29 C.F.R. 1910.1020, the general industry standard for Access to Employee Exposure and Medical Records in relation to Toxic and Hazardous Substances, all employee medical records related to toxic substances or harmful physical agents must be maintained by the employer for 30 years (except employees who have worked less than one year).<sup>33</sup> The definition of toxic substances or harmful physical agents includes viruses that

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<sup>32</sup> Centers for Disease Control and Prevention. COVID-19: Quarantine and isolation. Updated March 30, 2022. <https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html>. Accessed April 22, 2022.

<sup>33</sup> 29 C.F.R. 1910.1020(d)(1)

have “yielded positive evidence of an acute or chronic health hazard in testing by, or known to, the employer,”<sup>34</sup> clearly encompassing SARS-CoV-2. Under this standard, medical records include any record concerning the health status of an employee that is made or maintained by healthcare personnel including laboratory tests, medical examinations, diagnoses, medical questionnaires and employee medical complaints,<sup>35</sup> all of which are records that covered employers are likely to collect as part of required employee COVID-19 health screening,<sup>36</sup> employee notification of employer,<sup>37</sup> and medical removal.<sup>38</sup>

There is no reason to distinguish medical information collected under the standard for Occupational Exposure to COVID-19 in Healthcare Settings from that covered by the general industry standard for Access to Employee Exposure and Medical Records. Both standards exist to improve worker health and safety through detection, treatment, and prevention of harmful diseases and disorders that may be contracted in the workplace. While collection of COVID-related medical records is crucial to interrupting concurrent transmission of the virus, maintenance of the records assists with identification of recurring patterns in viral transmission and assessment of policies and procedures to reduce transmission. The information may help in the appraisal of vaccine effectiveness and longevity as a workplace protection strategy and the development of an employer response to the sometimes long-term effects of COVID-19 on employees.

#### **A.9—Evolution of SARS-CoV-2 into a Second Novel Strain**

We agree that it is possible that a future variant of SARS-CoV-2 will have sufficient genetic drift to be designated another novel coronavirus strain but still result in a disease that is similar to COVID-19. OSHA’s final standard should specify that it applies not only to COVID-19, but also to subsequent related coronavirus strains that are transmitted through aerosols and pose similar risks and health effects.

It is also possible that a future variant of SARS-CoV-2 will have sufficient genetic drift to be designated another novel coronavirus strain and result in a disease that is significantly more virulent. The development of such a variant that is transmitted through aerosols and poses greater risks and more severe health effects may warrant a new ETS or prompt revision of the final standard.

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<sup>34</sup> 29 C.F.R. 1910.1020(c)(13)

<sup>35</sup> 29 C.F.R. 1910.1020(c)(6)

<sup>36</sup> 29 C.F.R. 1910.502(l)(1)

<sup>37</sup> 29 C.F.R. 1910.502(l)(2)

<sup>38</sup> 29 C.F.R. 1910.502(l)(4)

Thank you for the opportunity to comment on this important public health matter. For questions, please contact Juley Fulcher at [jfulcher@citizen.org](mailto:jfulcher@citizen.org).

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