

DLAI 6055.1

DSS-E

16 Jan 02

SAFETY AND OCCUPATIONAL HEALTH INSTRUCTION
(This publication has been revised significantly
and must be reviewed in its entirety.)

A. REFERENCES. See [enclosure 1](#)

B. PURPOSE. This instruction:

1. Implements DLAD 6055.1, DoDD 4715.1, DoDI 6055.1 and its implementing instructions (references 1-13), 29 Code of Federal Regulations (CFR) 1960 (reference 14), Executive Order 12196 (reference 15), and the Occupational Safety and Health Act (reference 16) as they apply to the DLA. [references](#)

2. Incorporates HQ DLA CAAE memorandum "Confined Space Entry Policy" (reference 17), HQ DLA CAAE memorandum "Ergonomics Program Requirements" (reference 18), HQ DLA CAAE memorandum "DLA Safety and Health Program Evaluation Protocol" (reference 19), and HQ DLA CAAE memorandum "Emergency First Aid, CPR Policy Change; Implementation of Occupational Safety and Health Administration (OSHA) Final Rule on Bloodborne Pathogens" (reference 20). [references](#)

3. Establishes DLA guidance and procedures for planning, organizing, implementing, and managing the DLA Safety and Occupational Health Program (hereinafter referred to as the SOH Program) including the Radiological Health Program. Detailed program requirements are provided in the enclosures to this instruction and implement or incorporate additional references at enclosure 1.

C. APPLICABILITY AND SCOPE. This instruction applies to all DLA military and civilian personnel regardless of where they are assigned or their status. This instruction also applies to non-DLA personnel, military and civilian, who are at DLA-controlled or DLA-occupied facilities to the extent to which DLA is responsible for providing workplaces and operations free of recognized hazards.

D. DEFINITIONS

1. Additional Duty Safety Monitor (ADSM). A person assigned additional duties of providing support to their supervisor or local chain of command in implementing the Safety and Occupational Health (SOH) Program. The ADSM provides the same type of SOH Program support to their commander or supervisor as is provided by a Safety and Occupational Health Official (SOHO), and receives technical guidance from their SOHO. Except where an ADSM meets the qualifications of an SOHP, the ADSM's primary job duties are not SOH, and do not need to meet the job qualifications of a SOH Professional. [interpretation](#)

2. Anthropometry. The study of the physical dimensions of people, including size, breadth, girth, distance between anatomical points, and joint range of motion. This information is used in the design and analysis of workstations, tools, and equipment.

3. Cumulative trauma disorders (CTDs). Disorders of the musculoskeletal or nervous system which are the result of, or contributed to by, biomechanical risk factors ([examples listed in enclosure 8, paragraph 7.a.](#)). CTDs are a class of musculoskeletal disorders involving damage to the tendons, tendon

sheaths, synovial lubrication of the tendon sheaths, and bones, muscles, and nerves. Synonymous terms include repetitive injury, occupational overuse syndrome, and repetitive strain.

4. Designated Agency Safety and Health Official (DASHO). The individual who is responsible for the management of the safety and health program within an agency, and is so designated or appointed by the head of the agency pursuant to 29 CFR 1960.6 (reference 14) and the provisions of Executive Order 12196 (reference 15). The DLA DASHO is the Director DLA Support Services (DLA DSS). The DoD DASHO is the Deputy Under Secretary of Defense for Installations and Environment [DUSD(I&E)].

5. Equivalent ergonomics training. A minimum of 40 hours training covering work-related musculoskeletal disorders (WMSDs); workstation and job design; hand tool design; current regulatory requirements and issues; analysis and design of manual materials handling tasks; analysis and design of the office environment; and conducting, analyzing, documenting, and presenting an ergonomic work-station evaluation, including hands-on experience.

6. Ergonomics. A body of knowledge about human abilities, human limitations, and other human characteristics that are relevant to the design of tools, machines, systems, tasks, jobs, and environments for safe, comfortable, and effective human use. The aim of the discipline is to fit the job to the person in order to--

Prevent the development of occupational injury or illness.

Reduce the potential for fatigue, error, or unsafe acts.

Increase effective, efficient work.

7. Executive secretary. The safety and occupational health official responsible to the Chair of the Safety and Occupational Health Council for administering Council meetings.

8. Facility. The term facility in this instruction pertains to a building where DLA employees work.

9. Field activities. All DLA organizations exclusive of HQ DLA.

10. Health care providers. Physicians, chiropractic physicians, nurse practitioners, nurses, occupational therapists, physical therapists, physician assistants, and other health care professionals and their related, supervised technicians (for example, certified occupational therapy assistants and licensed practical nurses). Health care personnel participating in the ergonomics program should have training in basic ergonomics and epidemiology and be up-to-date in the systematic recognition, evaluation, treatment, and rehabilitation of work-related musculoskeletal disorders (WMSDs).

11. Immediately dangerous to life or health (IDLH). An atmosphere that poses an immediate threat to life, would cause irreversible adverse health effects, or would impair an individual's ability to escape from a dangerous atmosphere.

12. Incidence rate. A measurement of the rate of new occupational injury and illness occurring in the working population. The incidence rate is calculated as follows:

interpretation

$$\text{Incidence rate} = \frac{\text{Number of new cases during the past 12 months} \times 100}{\text{Average population during the past 12 months}}$$

13. Industrial hygiene. The art and science devoted to the recognition, evaluation and control of environmental factors arising in or from the

workplace that may result in injury, illness, impairment, or affect the well-being of workers and members of the community.

14. Installation. The term installation in this instruction pertains to a location where DLA is the host agency.

15. ISA. Interagency Support Agreement.

16. Microtrauma. A series of minor stresses to the body, each of which alone does not cause discernible damage; however, their accumulation over time can lead to WMSDs. These disorders (injuries or syndromes) are also known as CTDs, overuse disorders, repetitive motion injuries, repetitive strain injuries, and occupational motion-related injuries.

17. MOU. Memorandum of Understanding.

18. Multiple causation. The combined effect of several risk factors in one job, operation, or workstation, which may increase the possibility of WMSDs.

19. Occupational WMSD hazards. Workplace conditions that may harm the worker: improperly designed workstations; tools and equipment; improper work methods; and excessive tool or equipment vibration. Other examples include aspects of workflow, line speed, posture, force required, work and rest regiment, and repetition rates.

20. Pinch grip. A grip that involves one or more fingers and the thumb.

21. PLFA. Primary level field activity.

22. Prevalence rate. A measurement of the level of all personnel currently suffering from occupational injury and illness, calculated as:

$$\text{Prevalence rate} = \frac{\text{Number of open cases in the past 12 months} \times 100}{\text{Average population during the past 12 months}}$$

23. SLFA. Secondary level field activity.

24. Safety and Occupational Health (SOH). All activities related to preventing mishaps, injuries, and illnesses for DLA operations, facilities, and personnel. The SOH Program includes but is not limited to operational risk management, occupational safety, traffic safety, industrial hygiene, ergonomics, occupational medicine, hearing conservation, radiation protection, and SOH training. interpretation

25. SOHO. Safety and Occupational Health Official. A safety and occupational health professional who manages or administers the SOH Program at organizational levels below the DASHO. The SOHO serves as a principal adviser, monitor, and point of contact for SOH matters to line commanders and managers responsible for implementing the SOH Program. The HQ DLA SOHO is the Director of Safety and Health.

26. Safety and Occupational Health Professional. A person meeting the Office of Personnel Management standards for one of the following job series, or their military equivalent, with professional SOH training and experience, and who is working in the SOH field as their primary duty. interpretation

Safety and Occupational Health Manager/Specialist GS-018

Safety Engineer GS-803

Fire Prevention Engineer GS-804

Industrial Hygienist GS-690

Fire Protection and Prevention Specialist/Marshal GS-081

Health Physicist GS-1306

Occupational Medicine Physician GS-602

Occupational Health Nurse GS-610
Safety Technician GS-019
Physical Science Technician GS-1311
Environmental Health Technician GS-699
Air Safety Specialist GS-1825
Chemist GS-1320
Health Technician GS-645
Highway Safety Manager GS-2125

27. SOP. Standard Operating Procedure.

28. TLFA. Tertiary level field activity.

29. Trained ergonomics personnel. Health care, industrial hygiene, environmental science, safety, or engineering personnel with approved training in ergonomics. Minimum acceptable training for activity-level trained ergonomics personnel.

30. Working community. All members of the work environment at all levels of authority. It consists of PLFA commanders, SLFA or field commanders, administrators, the designated PLFA Ergonomics Officer (EO), identified ergonomics personnel, occupational health care personnel, safety personnel, the Human Resources Customer Support Unit, contracting support, Operations and Maintenance Chief(s), Logistics Chief(s), employee representatives, supervisors, military and civilian personnel.

31. Work-related musculoskeletal disorders (WMSDs). The range of health problems arising from repeated stress to the body encountered in the workplace. These health problems may also affect the nervous and neurovascular systems and may include the various occupationally induced CTDS, cumulative stress injuries, and repetitive motion disorders. Health problems include damage to tendons, tendon sheaths, synovial lubrication of the tendon sheaths, bones, muscles, and nerves of the hands, wrists, elbows, shoulders, neck, back, and legs. Some WMSDs that are reported include chronic back pain, carpal tunnel syndrome, DeQuervains disease, epicondylitis (tennis elbow), Raynaud's syndrome (white finger), synovitis, tenosynovitis, stenosing tenosynovitis, crepitans (trigger finger), and tendinitis.

32. Worksite. A work area or work environment larger than an individual workstation. Includes an employee's general work area or environment with one or more workstations where limited functions are performed (e.g. loading dock, storage bay, etc). For example, the worksite may change during a road construction project, but the workstations can remain the same (e.g. driver, loader, paver etc.).

33. Workstation. An individual person's work area, where set tasks are performed using limited tools or equipment such as a grinding bench, computer terminal, truck cab or an individual inspection station.

E. PROCEDURES

1. GOALS AND OBJECTIVES

a. HQ DLA. The HQ DLA SOHO will develop long term goals and objectives for issuance by the DLA Director that are consistent with the policies of the Department of Defense. By 15 July of each year, the HQ DLA SOHO will also prepare annual goals, objectives, and planned activities for the SOH program for the next fiscal year. As a minimum, DLA will use the following DoD Corporate Measures of Merit in measuring achievement of goals and objectives.

interpretation

- (1) Military Accidental Fatality Rate.
- (2) Civilian Lost-time Injury Rate.
- (3) Significant Threshold Shift (STS) Rate.

- (4) Severity Rate - lost workdays per 100 worker-years per year.
- b. FIELD ACTIVITY COMMANDERS AND ADMINISTRATORS will use the Director's goals and objectives to develop and implement their SOH Program strategies.

2. DLA PERSONNEL AT CONTRACTOR FACILITIES OR WORK SITES

a. DLA commanders/senior directors/managers will ensure that DLA employees are provided the same SOH Program protection whether working at DLA or at contractor facilities. The PLFA SOHO will provide SOH Program support to the commanders/senior directors/managers of DLA personnel working at contractor facilities, and will develop specific written procedures that implement the SOH Program for these personnel.

b. If the PLFA SOHO seeks to obtain corrective action at a contractor facility or work site, the request will be sent via the Administrative Contracting Officer who will inform the contractor of the need for corrective action.

3. SAFETY AND OCCUPATIONAL HEALTH COUNCILS (SOHCs). HQ DLA and Field Activities will establish SOHCs. Field units/locations may establish SOHCs or participate in their hosts' council meetings. Where there is more than one DLA organization located in a commuting area, the senior commander in the area may establish an SOHC that includes representation by senior personnel and SOHOs from those organizations. Other safety and health councils, such as a Radiation Control Council or an ergonomics committee, may be established and follow this format or may be combined with the SOHC. Close coordination between SOHOs within the organizations represented will be necessary in an effort to ensure the SOHC meetings are productive for all concerned. DLA SOHCs will:

- a. meet quarterly.
- b. publish minutes.
- c. include as a minimum the following members
 - (1) Activity commander or deputy, Chairman
 - (2) Safety and health official, Executive Secretary
 - (3) Recognized employee representative
 - (4) Occupational medical representative, when applicable
 - (5) Senior management officials
 - (6) Other personnel as appropriate
- d. Include as a minimum the following agenda items. The agenda will be published and distributed to members prior to meeting time.
 - (1) Mishap data
 - (2) Program training
 - (3) New standards
 - (4) Program goals
 - (5) Hazard abatement
 - (6) Significant incidents
 - (7) Other items as locally determined

4. PROGRAM OVERSIGHT

a. The HQ DLA SOHO will conduct an onsite evaluation of each PLFA's SOH Program at least once every three years to assess the adequacy of program compliance, using the criteria at enclosure 2. Evaluations may also be conducted more frequently to implement HQ initiatives. These oversight evaluations will assess PLFA SOH Program elements and will include on-site visits to secondary or lower field activities.

b. PLFA SOHOs will conduct onsite SOH Program evaluations of their subordinate activities annually. PLFAs may choose to perform evaluations triennially for subordinate activities receiving a satisfactory rating or better based on criteria established by the PLFA commander. PLFAs may establish agreements to have these evaluations conducted by organizations which are geographically closer or have needed technical expertise. The

parent PLFA retains responsibility for funding the evaluations and addressing the results.

5. FEDERAL AND NONFEDERAL SAFETY AND HEALTH ORGANIZATIONS. DLA activities are encouraged to participate in the functions and programs of Field Federal Safety and Health Councils. The senior SOHO should represent the DLA organization. When the senior SOHO is unable to attend due to other commitments, a representative who can speak for the senior SOHO should attend. Civilian employee representatives are encouraged to attend when practical. Attendance at these functions is considered "official business."

6. SAFETY AND HEALTH CONFERENCES. Attendance and participation of DLA safety and health personnel in regional and national occupational safety and health conferences is expected and strongly encouraged. Representation by an organization's senior SOHO at DLA Safety and Health Conferences is expected. If the senior SOHO is unable to attend due to other commitments a representative who can speak for the senior SOHO should attend.

7. DoD POSTER. The DD Form 2272, DoD Occupational Safety and Health Protection Program poster, shall be posted clearly and conspicuously in each establishment and updated as necessary. The Designated Agency Safety and Health Official (DASHO) for Defense Logistics Agency is the Director DLA Support Services (DLA DSS) ([see definition for DASHO](#)).

8. ISAs, MOUs, and CONTRACTS

a. When ISAs, MOUs or contracts are used to support the SOH Program, the SOHO or designated representative will provide their input to the ISA/MOU coordinator or contracting officer prior to finalization of the document.

b. Offices responsible for preparing or revising ISAs, MOUs, and contracts with potential SOH impact will coordinate these documents with SOHs at levels no lower than the PLFA to ensure proper measures are included in various functions to meet safety and health requirements. **interpretation**

c. SOHs will evaluate ISAs, MOUs, and contracts for SOH program support at least annually for effective implementation as a part of the annual SOH Program evaluations. Evaluations should include, as a minimum, the degree and quality of:

- (1) host safety inspections of DLA operations and workplaces;
- (2) industrial hygiene (IH) and occupational medicine support provided by the host;
- (3) inclusion of DLA hazards in the installation hazard abatement plan, and Public Works/DEH/Engineering support in responding to hazards;
- (4) training provided to the DLA organization;
- (5) notification of SOH meetings;
- (6) vehicle licensing and maintenance support; and
- (7) Fire Department training/fire fighting support.

9. STANDARDS. SOHs will maintain or have ready access to a current copy of DLA and referenced SOH Program standards applicable to their organization.

a. BASIC SOH STANDARDS. DLA will comply with OSHA final and emergency temporary standards in 29 CFR 1910, 1915, 1926, and 1960 (references 14, 21-23); with DoD SOH policy (references 2-13); and other applicable regulatory standards related to SOH that are issued under statutory authority by DoD or other Federal agencies (e.g. Departments of Transportation and Energy, the Environmental Protection Agency, the Nuclear Regulatory Commission, and the Food and Drug Administration). For non-DLA installations, DLA will use the more protective of DLA or host installation standards. For overseas locations, DLA will protect local national employees to the more protective of DLA or host nation standards. The SOHO will notify the HQ DLA SOHO through command channels of host installation or host nation standards being used.

b. DLA SUPPLEMENTARY STANDARDS

(1) ADOPTING SUPPLEMENTARY STANDARDS. DLA line managers and SOHOs shall identify through command channels to the HQ DLA SOHO, workplaces where OSHA standards apply but do not cover, or only partially cover, existing conditions, or are found to be not protective of personnel. The HQ DLA SOHO will identify national consensus or other standards as candidates for adoption as required by the National Institute of Standards and Technology Act ([P.L. 104-113, reference 22](#)). The DLA DASHO will adopt a DLA supplementary standard for these conditions where possible.

(2) American Conference of Governmental Industrial Hygienists (ACGIH) Threshold Limit Values (TLVs) for Chemical Substances. DLA will comply with the more protective of SOH standards for chemical substances issued by either OSHA or the American Conference of Governmental Industrial Hygienists in the latest edition of the Documentation of the Threshold Limit Values (ACGIH TLVs, reference 25). [interpretation](#)

(3) Noise. Noise standards are addressed in enclosure 3, Hearing Conservation.

c. ALTERNATE OSHA STANDARDS (29 CFR 1960.17, reference 14):

(1) If an HQ DLA organization or a DLA field activity determines an OSHA standard must be modified for application to particular working conditions that are not military unique, a proposed alternate standard shall be submitted through command channels to the HQ DLA SOHO. The document will include:

- (a) a statement explaining why the alternate standard is required;
- (b) a description of the proposed alternate standard;
- (c) an explanation of how the proposed alternate standard affords equal or greater protection than the standard or standards it replaces;
- (d) an indication that employee or employee representative comments were solicited, and a summary and analysis of such comments; and
- (e) a description of interim protective measures in effect pending decision on the alternate standard.

(2) If the review at any command level does not concur with the request, or if the review can not be completed within 30 days, the rationale for the nonconcurrence or status will be provided through command channels to the originating office.

(3) The HQ DLA SOHO will coordinate the proposed alternate standard with affected DLA union officials and potentially affected DoD Components, and submit the standard to the DoD DASHO for the DLA DASHO. The DoD DASHO will review the proposed standard and, barring non-concurrence, forward the standard to the Secretary of Labor for approval.

(4) Upon approval by the Secretary of Labor, the HQ DLA SOHO will distribute the approved standard to HQ DLA staff, DLA commanders, and SOHOs.

d. JOINT USE FACILITIES

(1) When there is a difference between a host DoD Component's and DLA's SOH Program standards, DLA personnel will follow the more protective standards.

(2) Where conditions exist which are not covered by a host DoD Component's standards, DoD/DLA standards will be applied.

(3) If unresolved conflicts between the host DoD Component's standards and DLA standards arise, the situation shall be referred through command channels for resolution by the HQ DLA SOHO. The HQ DLA SOHO will resolve the conflict with the senior SOH official for the host DoD Component.

e. CONTRACTOR STANDARDS DURING NATIONAL EMERGENCIES. Defense contractors are authorized under the OSH Act, P.L. 91-596 (reference 16) to apply for variations, tolerances, and exemptions to OSHA standards as may be necessary to avoid serious impairment of mobilization efforts during times of national emergency. Contractors submit applications and requests for interim orders to the Assistance Secretary of Labor for OSHA using the procedures in 29 CFR 1905.12 (reference 26). However, in the event that emergency legislation or Executive Orders transfer the authority of the Assistant Secretary of Labor for OSHA to the Secretary of Defense, DoD contractors would submit their requests to the Secretary of Defense through the HQ DLA SOHO, DLA

DASHO, and DoD DASHO for review. Requests will include, as a minimum, the elements required for applications to OSHA by [29 CFR 1905.12 \(reference 26\)](#):

- (1) The name and address of the applicant;
- (2) The address of the place or places of employment involved;
- (3) A specification of the provision of the OSH Act to or from which the applicant seeks a limitation, variation, tolerance, or exemption;
- (4) A representation showing that the limitation, variation, tolerance, or exemption sought is necessary and proper to avoid serious impairment of the national defense;
- (5) Any request which has been submitted for a hearing,
- (6) A description of how employees have been informed of the application and of their right to petition for a hearing.

10. HAZARD DETECTION, REPORTING, AND ABATEMENT

a. INSPECTIONS [interpretation](#)

(1) The SOHO will ensure that all DLA work places will be inspected annually by qualified SOH personnel to identify and assist in resolving hazardous conditions and work practices. Inspections shall be conducted more frequently to comply with regulatory authority (e.g., NRC, OSHA) or based on risk factors such as the exposure to and potential severity of hazards, actual accident experience, special emphasis programs, changes in the organization's staffing or workplaces, or other events that increase the risk of accidents and occupational illnesses. The extent of each inspection is at the discretion of the SOHO or as directed by the chain of command.

(2) Contractor Installations. Workplace visits in contractor installations where fewer than 25 DLA personnel are employed shall be at the discretion of the PLFA SOHO. The need for these visits will be based on potential hazards to which DLA personnel may be exposed. While no formal annual inspection is required, the PLFA SOHO is required to assist the DLA supervisor in assuring the health and safety of the PLFA's employees in the contractor facility.

(3) The SOHO will ensure that written inspection reports containing inspection findings, recommended corrective actions, and Risk Assessment Codes (RACs) are submitted to the senior official responsible for the inspected organization.

(4) Inspections and hazards will be entered and tracked in the DLA Safety and Health Information and Reporting System (SHIRS, details in enclosure 4). Where SHIRS is not available, hazard information will be tracked locally using the DLA Form 1404a, "Hazard Report Log". RAC 1, 2, and 3 hazards unabated after 30 days will be tracked locally on a DLA Form 1691, "Hazard Abatement Log". Local organizations will forward DLA Form 1404a and DLA Form 1691 monthly to the SOHO for entering into the SHIRS.

(5) An employee representative shall be given an opportunity to accompany the inspector during the physical inspection of any workplace and should be encouraged to participate and assist in identifying unsafe or unhealthful working conditions.

(6) Inspection officials shall be authorized to deny the right of accompaniment to any person whose participation interferes with a fair and orderly inspection.

(7) Any employee shall be afforded an opportunity to bring unsafe or unhealthful working condition to the attention of the inspector during the course of the inspection.

b. FEDERAL OSH INSPECTIONS or INVESTIGATIONS

(1) DLA will permit Department of Labor (DOL) OSH Compliance Officers to conduct inspections or investigations. DLA commanders and SOHOs will follow OSHA inspection procedures from [DoDI 6055.1, "DoD Safety and Occupational Health Program," enclosure 3](#).

(2) DOL inspections/investigations, findings, and corrective actions will be reported to the HQ DLA SOHO immediately through command and SOHO channels. The SOHO responsible for the inspected facility will enter the OSHA inspection and hazards identified by OSHA into SHIRS.

c. EMPLOYEE HAZARD REPORTING AND RESPONSE SYSTEM. A hazard reporting system shall be instituted within each field activity for employees and their local employee representative to report hazards.

(1) REPORTING. Field activity SOHOs will ensure that employees and their local employee representatives are aware of procedures to report hazards, and are encouraged to report hazards. Hazards may be reported orally or in writing to supervisors, SOHOs, or ADSMs. Employees will be encouraged to make oral reports to supervisors as the most prompt and effective method of identification, especially for imminent hazards. SOHOs should encourage employees to use DLA Form 1404 "Hazard Report" when reporting hazards in writing. SOHOs shall ensure that forms are readily available at workplaces for employees to use, either in hard copy or through employee access to the forms on Form Flow.

(2) INVESTIGATIONS. SOHOs will ensure the investigation of hazard reports as soon as possible, but within one workday for imminent danger situations, three working days for potentially serious situations, and 20 working days for lesser conditions. Hazard investigations will be entered into SHIRS. Where SHIRS is not available, investigations will be recorded on a DLA Form 1591 and forwarded to the SOHO for entering into SHIRS.

(3) RESPONSE. The responsible supervisor or SOHO who receives the hazard report will provide a response to the originator. All affected DLA and non-DLA personnel will be notified of hazards and hazard abatement actions.

d. HAZARD ABATEMENT [interpretations](#)

(1) IMMINENT DANGER. Immediate action shall be taken to eliminate or reduce hazards that constitute imminent danger situations (RAC 1 with hazard severity category I or II and accident probability category A), i.e., commanders and managers shall stop work and withdraw exposed personnel until the above action is taken.

(2) Hazards will be categorized and prioritized for abatement following the procedures of [DoDI 6055.1, enclosure 7 \(reference 3\)](#). PLFA SOHOs will use SHIRS to track hazards for abatement.

e. PROTECTION AGAINST REPRISAL

(1) As a matter of equity and to protect the integrity of both the hazard identification system and accident investigations, DLA will protect its personnel from coercion, discrimination, or reprisals for participation in the SOH program. Personnel shall be provided individual anonymity, when requested; provided prompt, impartial investigation of allegations of reprisal; and provided appropriate administrative action when such allegations are substantiated. The use of Inspector General channels to investigate such allegations is appropriate for military complaints. Civilian employee complaints shall be processed through the negotiated grievance procedure, if available; otherwise, through the administrative grievance procedure. Factfinding investigations of allegations of reprisal raised under the civilian complaints procedures may be conducted by the Inspector General or other appropriate organizations.

(2) Under the provision of [29 CFR 1960.46, "Agency Responsibility, Allegation of Reprisal"](#) (reference 14) protection against reprisal extends specifically to the right of a DoD civilian to decline to perform an assigned task because of a reasonable belief that, under the circumstances, the task poses an imminent risk of death or serious bodily harm, coupled with a reasonable belief that there is insufficient time to seek effective redress through normal hazard reporting and abatement procedures. In this situation, both the affected employee and local management shall be entitled to the considered opinion of a qualified safety, industrial hygiene, fire prevention, or health professional on the extent of the hazard.

11. EDUCATION AND TRAINING. Education and training will be provided as employee protection to reduce job-related injuries, illnesses and accidents to the maximum extent possible, and to comply with applicable standards and regulations. Field activities may provide supplemental training. Distance learning can be offered only when a qualified person is available to answer trainee's questions during the training period.

a. EMPLOYEES

(1) GENERAL TRAINING. Supervisors at all levels will ensure their employees are adequately trained initially to prevent mishaps, injury and illness. interpretation Supervisors will also provide periodic SOH training and information to employees at the frequency needed to control the risk to the employees (e.g., quarterly safety meetings; weekly tailgate meetings; daily briefings on weather conditions, new hazardous conditions, or lessons learned from recent mishaps). Training will include but not be limited to:

(a) known hazardous operations and conditions, and procedures to follow to prevent mishaps, injury, and illness;

(b) the need to identify hazardous operations or conditions to supervisors or SOH professionals for corrective action;

(c) the location and availability of the OSHA poster, SOH standards and program requirements, and DLA SOH records applicable their workplaces; and

(d) the authority of employees to contact OSHA to request a workplace inspection and to meet with OSHA during an inspection.

(2) LOCAL AREA HAZARD SAFETY BRIEFING. DLA field activities shall develop and keep current pertinent safety and health briefings for any unique local area conditions; i.e., driving conditions, driving laws, weather conditions, and any potential health problems or hazardous conditions on and off the installation. SOHOs shall develop procedures to ensure that all visiting personnel receive this briefing prior to performing official duties or being released on personal time (DoDI 6055.1, reference 3).

interpretations

(3) TASK TRAINING. Employees assigned to new positions or new tasks will be provided training on the hazards of the new tasks prior to performing the tasks to enable them to perform the work in a safe and healthful manner. Training will meet or exceed the requirements of the OSHA standard applicable to the hazard or task. Training will be repeated periodically as needed to meet OSHA requirements or to reduce risk to employees. Examples of task training requirements include but are not limited to:

(a) Permit required confined spaces

(b) Lock-out tag-out

(c) Powered Industrial Vehicles

(d) Traffic Safety

(e) Hazard Communication

(f) Personal Protective Equipment (PPE)

(g) Respiratory Protection

(h) Asbestos

(i) Employee access to medical records

(4) Recording Training. All SOH employee training will be recorded on the Standard Form (SF) 7B and placed in the employee's personnel file with copies of training certificates. Training records will include:

(a) name of the trainee,

(b) type of training performed,

(c) date training completed, and

(d) name of trainer.

b. SUPERVISORS. Supervisors at all levels will receive a minimum of 4 hours of initial SOH training. The PLFA or Installation SOHO is encouraged to modify the training to meet local needs, and may include the following topics.

(1) Introduction to the SOH Program

(2) SOH Program Elements

(3) OSHA Requirements

(4) Supervisor's SOH Program Responsibilities

(5) Risk Management Procedures

(6) Employee Involvement in the Program

(7) Hazard Identification and Control

(8) Mishap Prevention

(9) Mishap Investigation and Reporting

(10) Industrial Hygiene

(11) Occupational Medical Surveillance

- (12) Radiological Health
- (13) Ergonomics
- (14) Personal Protective Equipment
- (15) Office Safety
- (16) Permit Required Confined Space Entry
- (17) Vehicle Safety

c. COMMANDERS. The DLA Director, Vice Director, and Executive Director, and subordinate commanders and directors, will receive an orientation and background information, as required, to establish policy and direct the management of their SOH Program. Within 60 days of the change of leadership of a DLA organization, the organization's SOHO will brief the new director or commander on the organization's history and current status of SOH efforts. This comprehensive briefing will also detail future initiatives planned to move the organization toward DLA goals, including the DoD goal of zero accidents, along with the logic and rationale detailing how and why these actions are expected to be effective ([DoDI 6055.1, reference 3](#)).

d. EMPLOYEE REPRESENTATIVES. Recognized employee representatives will receive SOH Program training to enable them to assist in ensuring safe and healthful working conditions and practices, to conduct workplace safety and health inspections, and as required in the locally negotiated contract.

e. SOHOs, SOHOs' support staff, and SOH professionals will be provided:

(1) Annual formal and informal training, educational programs, professional conferences, management training, and other activities that enhance their abilities to function effectively as professional SOH program advisors to commanders and management officials.

(2) Annual career development programs that enable them to meet present and future SOH program needs of the Agency and local Command, and that can lead to professional certification.

f. ADSMs will:

(1) receive adequate training to achieve the technical competence necessary to perform their assigned safety and health duties, and

(2) attend the DLA Safety Monitor course or a locally-developed equivalent.

g. SHIRS training will be provided to those individuals designated by SOHOs.

12. SPECIFIC PROGRAM REQUIREMENTS. Field Activities will comply with the specific program requirements detailed in enclosures 2 through 16.

F. RESPONSIBILITIES

1. HQ DLA

a. The Director will:

(1) Establish the DLA SOH Program.

(2) Appoint a Designated Agency Safety and Health Official (DASHO).

(3) Ensure that the DLA budget submission includes appropriate financial and other resources to effectively implement and administer the SOH Program under 29 CFR 1960.7 "Financial Management" (reference 14) and 29 U.S.C. 651 (reference 16).

(4) After receiving the initial comprehensive SOH program briefing:

(a) publish a personal policy letter stating expectations for safety and health, outlining support for the SOH Program, and recognizing that safety and occupational health is a command program executed by management and supervisory personnel with technical assistance provided by the Safety and Occupational Health Official (SOHO) ([DoDI 6055.1, paragraph 5.4, reference 3](#)).

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(b) revisit and decide upon the proper organizational placement and communication channels between the leadership and the SOH staff. These are decisions each agency must make, keeping in mind the necessity for direct lines of communication between top activity leaders and their SOH policy and operational staffs.

b. The DASHO will:

(1) Serve as the primary DLA point of contact for SOH Program issues to the DoD DASHO, the Deputy Under Secretary of Defense for Environmental Security [DUSD(ES)].

(2) Consult with appropriate national officials of unions representing DLA employees, as required by Executive Order 12196 (reference 15), on matters pertaining to the SOH Program.

(3) Appoint a HQ DLA SOHO to assist the Director and the DASHO in implementing the SOH Program.

c. The HQ DLA SOHO will plan, develop, and provide day-to-day administration of the DLA SOH Program. This includes but is not limited to the following.

(1) Develop SOH Program policies, instructions, and guidance in accordance with mission requirements.

(2) Establish performance measures for safety and health, develop short term and long term program performance goals, and monitor accomplishment of goals in conjunction with senior management at all levels.

(3) Develop and annually update a three year plan containing as a minimum goals and objectives, plans for achieving objectives, program evaluation schedule, training schedule, and resources required to complete the work.

(4) Conduct field activity SOH program evaluations annually ([see paragraph E.4.](#)).

(5) Develop and maintain comprehensive mishap prevention, reporting, and investigating programs.

(6) Develop SOH education and promotion programs.

(7) Provide SOH technical assistance, guidance, and headquarters staff support to DLA activities.

(8) Provide written interpretation of OSHA standards and serve as the primary DLA point of contact on all OSHA matters requiring liaison with the Office of Federal Agency Programs, U.S. Department of Labor.

(9) Provide written interpretation of DoD standards, and serve as the primary DLA representative to the Assistant Deputy Under Secretary of Defense for Force Protection [ADUSD(FP)], and to the DoD Safety and Occupational Health Committee.

(10) Review Headquarters specifications, guidance, instructions, and other Headquarters publications for conformance with OSHA, DoD, and other applicable standards.

(11) Establish the SOH Program training requirements.

(12) Prepare the annual OSHA report on past performance and future plans.

(13) Host periodic conferences and symposia among other SOH professionals.

(14) Provide technical training to HQ SOH staff designed to keep professionals current in their field.

d. HQ Executive Directors, Staff Directors, Chiefs, Office Heads, and Program Managers will coordinate with the HQ DLA SOHO to:

(1) Consult on technical interpretations of applicable standards to ensure uniform application.

(2) Identify during the planning, design, and construction of new or upgraded facilities applicable standards and practices for the purpose of anticipating and eliminating hazards.

2. DLA Field Activities

a. Field Activity Commanders, Directors, and Administrators will:

(1) Implement an SOH Program to protect DLA resources and personnel from mishaps, injury, and illness.

(2) Publish a statement outlining support for the SOH Program and recognizing that safety is a Command program executed by management and supervisory personnel with technical assistance provided by the qualified SOHO. Commanders and Directors will review the statements annually and republish, as needed.

- (3) Provide appropriate resources to support the SOH Program under 29 CFR 1960.7 "Financial Management" (reference 14).
 - (4) Provide SOH Program services to tenant and satellite activities in accordance with contractual agreements, MOUs, or ISAs.
 - (5) Appoint an SOHO to provide technical and administrative support in implementing the SOH Program.
 - (6) Appoint one or more ADSMs, as needed, to assist them in implementing the SOH Program.
 - (7) Establish Safety and Occupational Health Councils and committees as outlined in [DoDI 6055.1, enclosure 2 \(reference 3\)](#).
 - (8) Provide managers, supervisors, and employee representatives, as required by [29 CFR 1960.59](#) (reference 14) and the locally negotiated contract, with SOH training that will give them an understanding of the SOH Program goals and supervisor responsibilities. [See paragraph E.12. for training content](#).
 - (9) Provide employee SOH training in accordance with OSHA, DoD, and other applicable Federal, state, and local requirements. Consider the recommendations of the SOHO for training content, structure, and frequency.
 - (10) Consult with employee representatives on matters pertaining to the SOH Program.
 - (11) Ensure that DLA personnel are not subject to restraint, interference, coercion, discrimination, or reprisal by virtue of their participation in the DLA SOH Program.
 - (12) Identify, during the planning, design, and construction of new or upgraded facilities, applicable standards and practices for the purpose of anticipating and eliminating hazards.
 - (13) Ensure standard operating procedures and other in-house directives are coordinated with the SOHO to ensure appropriate SOH requirements are included.
 - (14) Ensure supervisors' performance standards contain SOH performance requirements in accordance with [DLAD 1434.1 \(reference 27\)](#).
- b. Field Activity SOHOs will:
- (1) Advise and assist the Commander/Director/Administrator in implementing the Program.
 - (2) Develop SOH Program elements to prevent mishaps, injuries, and illnesses, and to comply with this instruction.
 - (3) Evaluate work areas for compliance with the SOH Program.
 - (4) Identify and investigate workplace hazards and unsafe work practices.
 - (5) Investigate mishaps involving fatalities, total disability and permanent partial disability injuries/illness, and Class A property damage, in addition to the supervisor's investigation.
 - (6) Advise supervisors, in conjunction with Human Resources and Occupational Medicine, on work conditions suitable for returning injured or disabled employees back to work.
 - (7) Develop and maintain documents as needed to operate the SOH Program and comply with legal and policy requirements (e.g., supplemental instructions, local policies, inspection reports, exposure data, mishap investigations, SOH Program Annual Plans, etc.).
 - (8) Develop an annual SOH plan in coordination with local senior management containing as a minimum: goals and objectives, including HQ DLA goals and objectives; plans for achieving objectives; inspection schedule; training schedule; and resources required to complete the work. A 3-year plan with annual updates is recommended to address achievement of long term goals and objectives.
 - (9) Establish SOH program promotional activities as deemed necessary by their Commander/Administrator.
 - (10) Determine the content, structure, and frequency of SOH Program training.
 - (11) Provide technical guidance and support to ADSMs within their organization.
 - (12) Identify employee training requirements and maintain the status of training completion

(13) Designate a respiratory protection program administrator to administer or oversee the respiratory protection program and conduct the required evaluations of program effectiveness (enclosure 5).

(14) Provide technical training to SOH Professionals and ADSMs to keep them current in their field.

c. Additional Duty Safety Monitors (ADSMs)

(1) Advise and assist their chain of command in implementing the SOH Program in coordination with their respective SOHO.

(2) Identify and investigate workplace hazards, unsafe work practices, and accidents.

(2) Evaluate work areas for compliance with the SOH Program.

(3) Provide SOH Program promotional activities.

(4) Seek SOH Program technical guidance and support from their respective SOHO.

3. Supervisors at all levels, to the extent of their authority, shall:

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a. Furnish their employees a place of employment and operations that are free from recognized hazards.

b. Identify, investigate, and correct workplace hazards and unsafe work practices.

c. Investigate and report work-related mishaps, injuries, and illnesses within six working days of knowing of the incident using a DLA Form 1591, "Supervisory Mishap Report" ([29 CFR 1960.67\(b\)](#) and [1960.68](#), reference 14).

d. Notify their supervisory chain of command if correction of a hazardous condition is not possible at their level.

e. Provide their personnel with sufficient information and training to perform their jobs safely including specialized training on specific hazards associated with the work to be performed. Document training provided (see paragraph (4))

f. Provide employees with personal protective equipment (PPE), ensure employees are trained to use it, and maintain the equipment in good condition (detailed in enclosure 6).

g. Ensure their employees comply with applicable SOH policies, instructions, standards, and procedures.

h. Coordinate standard operating procedures with assigned SOHOs or ADSMs.

4. Employees at all levels will:

a. Comply with the standards, rules, regulations, and orders issued by DLA which are applicable to his/her own actions and conduct ([29 CFR 1960.10\(a\)](#), reference 14).

b. Correctly use and maintain personal protective equipment, safety equipment, and other devices and procedures.

c. Immediately report unsafe or unhealthful working conditions to their supervisor.

d. Immediately report work-related mishaps, injuries, and illnesses to their supervisor.

e. Shall be authorized official time to participate in required SOH activities.

5. Contracting and Procuring Officials at all levels will coordinate with their respective SOHO to ensure DLA procurement actions related to goods, hazardous materials, equipment, supplies, services, inspections, new construction, or upgrading or retrofitting of facilities comply with DoD SOH standards and do not present hazards to DLA employees or property.

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G. EFFECTIVE DATE. This publication is effective immediately

H. INFORMATION REQUIREMENTS. This paragraph identifies Report Control Symbol (RCS) information and forms. All hazards and mishaps will be entered into the Safety and Health Information Reporting System (SHIRS) using procedures in enclosure 4. At organizational levels where SHIRS is unavailable, information will be collected on DLA Form 1404, Hazard Report, DLA Form 1404a, Hazard Report Log, and DLA Form 1591, Supervisory Mishap Report, and forwarded to the respective SOHO for entry into SHIRS.

BY ORDER OF THE DIRECTOR

RICHARD J. CONNELLY
Director
DLA Support Services

Enclosures:

1. [References](#)
2. [Safety and Health Program Evaluation Protocol](#)
3. [Hearing Conservation](#)
4. [Mishap and Hazard Investigation and Reporting](#)
5. [Respiratory Protection](#)
6. [Industrial Hygiene Program](#)
7. [Occupational Medicine Services](#)
8. [Ergonomics](#)
9. [Permit-Required Confined Spaces](#)
10. [Personal Protective Equipment](#)
11. [Hazard Communication \(HazCom\)](#)
12. [Powered Industrial Truck Operator Training](#)
13. [Ionizing Radiation](#)
14. [Blood-Borne Pathogens](#)
15. [Traffic Safety](#)
16. [Radiofrequency Radiation](#)

References

1. [DLA Directive 6055.1, "Safety and Occupational Health Directive," July 2, 1996.](#)
2. [DoD Directive 4715.1, "Environmental Security," February 24, 1996.](#)
3. [DoD Instruction 6055.1, "DoD Safety and Occupational Health \(SOH\) Program," August 19, 1998.](#)
4. [DoD Instruction 1010.15, "Smoke-Free DoD Facilities," January 2, 2001.](#)
5. [DoD Instruction 6050.5, "DoD Hazard Communication Program," October 29, 1990.](#)
6. [DoD Instruction 6055.4, "DoD Traffic Safety Program," July 20, 1999.](#)
7. [DoD Instruction 6055.5, "Industrial Hygiene and Occupational Health," January 10, 1989.](#)
8. [DoD 6055.5-M, "Occupational Medical Surveillance Manual," May 1998.](#)
9. [DoD Instruction 6055.6, "DoD Fire and Emergency Services Program," October 10, 2000.](#)
10. [DoD Instruction 6055.7, "Accident Investigation, Reporting, and Record Keeping," October 3, 2000.](#)
11. [DoD Instruction 6055.8, "Occupational Radiation Protection Program," March 31, 1989.](#)
12. [DoD Instruction 6055.11, "Protection of DoD Personnel from Exposure to Radiofrequency Radiation and Military Exempt Lasers," February 21, 1995.](#)
13. [DoD Instruction 6055.12, "DoD Hearing Conservation Program \(HCP\)," April 22, 1996.](#)
14. Occupational Safety and Health Administration (OSHA), Department of Labor, "Basic Program Elements for Federal Employees Occupational Safety and Health Programs and Related Matters," October 21, 1980 ([29 CFR 1960](#)).
15. [Executive Order 12196, "Occupational Safety and Health Programs for Federal Employees," February 26, 1980.](#)
16. [Public Law 91-596, "Occupational Safety and Health Act of 1970," as amended \(29 U. S. C. 651 et seq. \(1976\)\).](#)
17. HQ DLA CAEE memorandum, "Confined Space Entry Policy," May 23, 1997, superseded.
18. HQ DLA CAEE memorandum, "Ergonomics Program Requirements," March 19, 1999, superseded.
19. HQ DLA CAEE memorandum, "DLA Safety and Health Program Evaluation Protocol," July 17, 1998, superseded.
20. HQ DLA CAEE memorandum "Emergency First Aid, CPR Policy Change; Implementation of Occupational Safety and Health Administration (OSHA) Final Rule on Bloodborne Pathogens," 21 FEB 1992, superseded.

21. Occupational Safety and Health Administration, 29 Code of Federal Regulations, Part 1910, "Safety and Health Standards for General Industry."
22. Occupational Safety and Health Administration, 29 Code of Federal Regulations, Part 1915, Safety and Health Standards for Shipyard Employment.
23. Occupational Safety and Health Administration, 29 Code of Federal Regulations, Part 1926, Safety and Health Standards for Construction.
24. [Public Law 104-113, "National Technology Transfer and Advancement Act of 1995." March 7, 1996 \(15 U. S. C. 272\(b\)\).](#)
25. The American Conference of Governmental Industrial Hygienists, "The Threshold Limit Values for Chemical Substances and Physical Agents and Biological Exposure Indices," 1998.
26. Occupational Safety and Health Administration, 29 Code of Federal Regulations, Part 1905, "Rules of Practice."
27. [DLA Directive 1434.1, "Performance Appraisal for the Performance Management System \(PMS\)," 30 July 1997.](#)
28. [DoD Directive 5400.11, "DoD Privacy Program," December 13, 1999.](#)
29. [DoD Instruction 6205.2, "Immunization Requirements", October 9, 1986.](#)
30. [Office of Personnel Management, 5 Code of Federal Regulations, Part 339, Medical Qualification Determinations.](#)
31. [Title 29 Code Of Federal Regulations, PART 1630--Regulations to Implement the Equal Employment Provisions of the Americans With Disabilities Act, Part 1630.14, Medical Examinations and Inquiries Specifically Permitted .](#)
32. [US Department of Health and Human Services, NIOSH, DHHS \(NIOSH\) Publication No. 94-110, "Applications Manual for the Revised NIOSH Lifting Equation," January 1994.](#)
33. Department of Labor, "Regulations to Implement the Equal Employment Provisions of the Americans with Disabilities Act" (29 CFR 1630).
34. National Fire Protection Association (NFPA) 306, "Standard for the Control of Gas Hazards on Vessels," 1997.

Safety and Health Program Evaluation Protocol

DLA SAFETY AND HEALTH PROGRAM EVALUATION PROTOCOL

A. PURPOSE. This information will be used as a guide to conduct DLA Safety and Health (SOH) Program Evaluations. It will assist evaluation teams to determine if primary level field activity (PLFA) Safety and Health Program implementation is in compliance with Department of Defense (DoD) and Defense Logistics Agency (DLA) policies, directives, and instructions. The effectiveness of PLFA safety and health programs is assessed by visiting the organizations to evaluate them against key criteria that are considered critical to implementing a successful program.

B. FREQUENCY. Safety and Health Program Evaluations are conducted at all DLA PLFAs once every 3 years to review program elements for implementation and effectiveness. Technical assist visits are also provided as determined by the DLA Director for Safety and Health.

C. RESPONSIBILITY. DLA Headquarters' Safety and Health teams will conduct field activity SOH Program evaluations in accordance with regulatory requirements from Occupational Safety and Health Administration (OSHA) standard 29 CFR 1960.79, DoD Instruction 6055.1, and DLA implementation guidance found in this instruction. The team may consist of two DLA professionals with assistance from field safety and health personnel as the need arises. A DLA Headquarters' safety and health professional will lead the evaluation team.

D. PROCEDURES

1. EVALUATION TEAMS. If the need arises, volunteers may be solicited from PLFA safety and health professionals. The DLA Headquarters' Director of Safety and Health will determine when the assistance of field personnel is necessary. If this need is identified, a letter to PLFA commanders requesting the assistance of field safety and health professionals on evaluation teams will be prepared and forwarded as appropriate. The cost of travel for field personnel providing assistance will be the responsibility of HQ DLA Environment and Safety (DSS-EH).

2. EVALUATION SCHEDULE. The HQ DLA SOHO will:

a. Update the evaluation schedule 45 days after the close of the fourth quarter of each fiscal year, designating a specific month for each visit.

b. Ensure that activities with a lost time case rate greater than the Federal average are identified for annual evaluation visits.

c. Assign a HQ DLA safety and health professional(s) to conduct the evaluation along with field professional(s) from different organizational areas if necessary.

d. Publicize the schedule to Headquarters safety and health personnel and field activities.

e. Forward a letter to activity commanders/administrators and their safety and health managers requesting volunteers for the evaluation teams if it is determined that field participation is needed. The letter will state that Headquarters DLA DSS-EH will provide TDY funding for field assistance on evaluations

f. Select volunteers and notify them of the target evaluations, dates, and initial arrangements.

3. PRELIMINARY/ADMINISTRATIVE PROCESSES. The HQ DLA Safety and Health Professional designated to lead the team will:

a. Contact the appropriate primary level field activity safety and health manager to negotiate acceptable dates to perform the evaluation.

b. Prepare an information package for PLFA commanders or administrators to use during the entrance briefing. The package should include at least, the following items.

(1) Lost time case rates for the current year with projected goals. Also include a 3-year history.

(2) Office of Workers' Compensation Cost for current year including a 3-year history.

(3) The current DLA Safety and Health Policy letter and other pertinent HQ DLA correspondence.

(4) Commanders' Checklist for Safety (October 30, 1995 memorandum).

(5) Management Responsibilities - Executive Summary for Safety. Occupational Health. Radiation. and Industrial Hygiene Programs.

c. Prepare and send formal notification of the evaluation to PLFA commanded administrator.

(1) Forward with the notification a list of requested data for review prior to the evaluation (see enclosure 1).

(2) Request an entrance briefing be arranged on the first day with the organization commander or deputy to discuss the purpose of the evaluation.

(3) Request arrangement of meetings any time during the visit with the local employee union representative and the compensation coordinator.

(4) Request visits be arranged to SLFAs to determine implementation and effectiveness of the SOH Program.

(5) Request an exit briefing be arranged with the organization Commander or appointed designee on the last day of visit to review findings and discuss recommendations for corrective action.

d. Review previous evaluation reports, activity replies and follow-up information; accident statistics and compensation costs; and other significant actions or information about the activity to obtain background knowledge prior to visit.

e. Coordinate evaluation arrangements with all team members.

E. ELEMENTS OF EVALUATION

1. Conduct an entrance and exit briefing with the commander, administrator, or designee.

2. Review records for the following administrative requirements.

a. Request the following information if not received prior to visit.

(1) **Organizational chart** showing placement of safety and health office and a list of SLFAs. Also obtain the current population for the activity [Reference: [29 CFR 1960.6\(b\)](#)].

(2) List of **safety and health professionals** with job titles and number of collateral duty personnel (Reference: [DoDI 6055.1](#) and [29 CFR 1960.6\(c\)](#)).

(3) **Mission and functions** statement for the local safety and occupational health functions [Reference: [29 CFR 1960.6\(b\)\(3\)](#)].

(4) Status of local **SOH councils** with written documentation of regular quarterly meetings. Check for written agendas, minutes and completion of action items (Reference: [DoDI 6055.1](#)).

(5) Written implementation of **DLA policy guidance**, policy letters, or any other supplementary program documents [Reference: [29 CFR 1960.12\(b\)](#)].

(6) **Annual safety and health plan** that outlines the SOH Program functions and scheduled events [Reference: [DoDI 6055.1](#) and [29 CFR 1960.6\(b\)\(4\)](#)].

(7) SOHO's review of ISAs and MOUs which establish contracts for a variety of SOH services received or provided.

(8) Check official bulletin boards for the **DoD Safety Poster** (DD Form 2272) and look to see if it has been filled in properly (Reference: [DoDI 6055.1](#) and [29 CFR 1960.12](#)).

(9) **Resources**

(a) Availability of appropriate resources for implementation and administration of the SOH Program, i.e., adequate personnel, personal protective equipment, mandatory OSHA training, occupational health services, industrial hygiene equipment and support, and computer equipment [Reference: [DoDI 6055.1](#) and [29 CFR 1960.7\(a\)](#)].

(b) A safety budget for correction of projects with RACs of 1 and 2 should be available for review (may be integrated into annual plan - 3a(3) above). [Reference: [DoDI 6055.1](#) and [29 CFR 1960.7\(c\)\(2\)](#)].

(c) Adequate funds budgeted for future safety and occupational health program initiatives [Reference: [29 CFR 1960.7\(a\)](#)].

(10) **Statement of safety responsibility** in all management and supervisory performance standards. To check this requirement, review random samples (at least 5-10 copies) of supervisory and management performance standards from official personnel folders (Reference: [DoDI 6055.1](#) and [29 CFR 1960.11](#)).

b. Meet with:

(1) The **local compensation coordinator** and review the status of liaison between the local SOHO and the compensation offices. How is SHIRS being utilized in both offices to further accuracy and consistency of numbers reported?

(2) The **local employee union** representative to determine interface between safety and the local union (Reference: Department of Labor, OSHA publication, Basic Program Elements for Federal Employee Occupational Safety and Health Programs and Related Matters, [29 CFR 1960.27](#) and [29 CFR 1960.59](#)).

c. Ensure that procedures are established for **hazard detection, reporting, investigation,** and correction (Reference: [DoD 6055.1](#) and [29 CFR 1960](#)).

(1) A hazard identification, reporting, and response program must be instituted. The existence of the program must be publicized explaining how to report a hazard (an unsafe condition or action) to the safety office. Instructions should also include procedures for appeal rights. Review the previous fiscal year **Hazard Report Log (DLA Form 1404a)** and **Hazard Abatement Log (DLA Form 1691)** or locally adopted forms with similar data to determine quality of report preparation, processing procedures, and completion of corrective action taken. Also review the Safety and Health Information Reporting System (SHIRS) for entry of hazard reports into the database (Reference: [DoDI 6055.1](#) and [29 CFR 1960.67](#) and [1960.68](#)).

(2) Review written **inspection procedures**, which should include a schedule for annual visits to sites supported by the local safety office. Take note that contractor worksites with fewer than 25 personnel are exempt but must be considered for inspection by the cognizant Safety Manager based on inherent risks and their mishap experience. Review a random sampling of written reports to determine if major deficiencies have been identified, risk assessment codes applied, notices prepared and posted as appropriate, and adequate follow up conducted to determine status of corrective measures. Determine if inspection findings are placed in SHIRS (Reference: [DoDI 6055.1](#), [29 CFR 1960.25](#) and [1960.26](#)).

d. Review the **safety and health training plan** to ensure all necessary training requirements are included. The plan should include appropriate training and schedule of classes for full-time SOH personnel, non-supervisory personnel, representatives of civilian employees, first-line supervisors, senior officials, functional job-related training for specified employees, and additional/collateral duty personnel (Reference: [29 CFR 1960, Subpart H \[1960.54 - .60\]](#) and [DoDI 6055.1](#)).

e. Review **mishap reporting and investigation** procedures. Determine the quality of reporting and timeliness of report submission to the Safety Office. Review the Safety and Health Information Reporting System (SHIRS) for reporting and investigation records. Where hard-copy mishap reports are used, review for quality and timeliness of reporting. Has SHIRS been publicized with responsibilities for supervisors? What is the lost time case rate, and/or number of total accident cases, fatalities (if any)? Review investigation procedures for accuracy and completeness. Check for corrective actions recommended and taken, management involvement, and any re-engineering of process (Reference: [DoDI 6055.7](#) and [29 CFR 1960.29](#), [1960.67](#), [1960.68](#), and [1960.70](#)).

f. Review how the selection and purchase of **personal protective equipment** (PPE) for employees working in potentially dangerous job areas is approved locally. Review written PPE program requirements for mandatory certification training guidance. Ensure that certification includes a statement that trainees have "demonstrated" an understanding of what was learned during training. Also review records for written certification of workplace assessment (Reference: [29 CFR 1910.132](#)).

g. Review the industrial hygiene and occupational health programs to determine if procedures are in place to provide employees with a healthful work environment that is free from recognized chemical, physical, or biological hazards. The following elements should be checked when evaluating the industrial hygiene and occupational health programs (Reference: [DoDI 6055.5](#) and [DLAD 6055.1](#)).

(1) Surveillance

(a) **Industrial Hygiene Surveillance.** Review records of comprehensive periodic evaluations that must be conducted for all potential health hazards in each workplace and ancillary facility. This evaluation is performed to ensure an effective occupational health program. This is the first step in establishing criteria for scheduling medical surveillance, environmental monitoring, health education, and issuing PPE. The evaluation should include the name of the installation/activity/directorate/division; work location; date the information was collected; name of evaluator; name of supervisor with phone number; description of operation; potential exposures; controls in effect; names and job series of people involved; and any follow up actions or recommendations (*Reference: [DoDI 6055.5](#)*).

(b) **Medical Surveillance and Records.** Visit the occupational health provider to discuss services received. Review records to ensure medical monitoring/surveillance received by employees working in hazardous areas is based on exposure data obtained during industrial hygiene evaluations/surveys. Ensure that all medical examinations required by OSHA 1910 standards and DoD regulations are conducted. Determine if procedures are in place to ensure that any personal health information obtained from the medical surveillance program is protected and used only as a management tool for occupational disease prevention, treatment, or adjudication of employee workers compensation claims, and employees have access to their exposure and medical records [*Reference: [1910.120\(f\)](#); 1910.1000-series chemical-specific standards; [DoDI 6055.5](#); [DoD 6055.5-M](#); [29 CFR 1910.1020](#)*].

(2) Review the **Industrial Hygiene (IH) implementation plan**, if available. The implementation plan defines the IH program policy, sets goals and objectives, establishes key program elements, and assigns specific IH program responsibilities.

(3) **Industrial Hygiene Survey database** for tracking may be used. The database should include:

(a) Exposure and sampling data

(b) Corrective and follow-up actions

(4) Ensure that industrial hygiene related concerns/hazards are recorded on the **Hazard Report Log**.

(5) Review **health hazard education** records. All personnel working in a hazardous area (as determined by the safety or IH evaluation/survey) must be trained on the health hazards associated with their occupation. In addition, they are to be informed of safe work practices, and educated in the use of appropriate protective equipment. Records of the individual's health hazard training must be documented and maintained (*Reference: DoDI 6055.5*).

(6) **Immunizations.** Are employees offered at Government expense those immunizations that the local medical officer determines are necessary to ensure occupational disease prevention? (*Reference: [DLAI 6055.1, enclosure 7](#)*)

(7) **Emergency Medical Treatment.** Are employees with job-related injuries and illnesses offered appropriate emergency medical care? And is related follow-up care for civilian employees provided? (*Reference: [DLAI 6055.1, enclosure 7](#)*)

(8) **Research and Development.** When necessary, is research and development performed to assess the effects and impact of specific environmental conditions, unique to the military, on personal health and well-being, and the development of criteria or other measures to reduce or prevent their impact on health status or work performance? (*Reference: DoDI 6055.5*)

(9) **Records Management.** Are civilian medical records maintained at providing medical treatment facilities, under the custody of medical personnel or personnel trained in medical records procedures? Note that the Human Resources Operations Center (HROC) may retain copies of Office of Workers' Compensation records for as long as necessary. Are there any military medical records? If so, the maintenance, retention, and disposition must be accordance with existing DoD documents. Are employees or employee representatives permitted access to those workplace records pertinent to their individual exposures? Are IH workplace monitoring and survey records retained for a minimum of 40 years? (Reference: [DoDI 6055.5](#) and [5 U.S.C. 552a](#) [formerly FPM Supplement 293-31, subchapter S6])

(10) **Equipment and space resources.** Is the number and type of industrial hygiene sampling equipment adequate to assess exposures? Is the equipment maintenance. calibration and storage space adequate to ensure accurate data collection?

(11) **Professional development of industrial hygienist.** Is adequate training received by personnel to ensure quality performance of IH functions? (Reference: [DoDI 6055.1](#))

(12) **Equipment Calibration Program.** Is there documentation that supports the required calibration of IH sampling equipment? This would include pre and post calibration of exposure assessment equipment, or other certified calibration documents.

h. **Other Programs.** Are the following programs needed or required at the facility? If so, do they meet regulatory requirements specified by the reference?

(1) **Hearing Conservation.** Does the facility have any noise hazardous areas? If they do, are actual noise exposure records available, and are the employees receiving the necessary training for hearing conservation? Does part of their medical surveillance include hearing evaluations on the exposed worker? (Reference: [DoDI 6055.12](#))

(2) **Confined Space Entry Program.** Does the DLA organization have confined spaces where employees may be required to enter? If they do, are there procedures established and equipment available to ensure their safety while working in such spaces? (Reference: [DLAI 6055.1, enclosure 9](#))

(3) **Hazard Communication Program.** Does the DLA organization have a written Hazard Communication Program? Are there employee training records, and does the program meet the requirements specified in the following references? (Reference: [29 CFR 1910.1200](#); [DLAI 6055.1, enclosure 11](#))

(4) **Process Safety Management Program.** Does the DLA organization have a Process Safety Management Program? If so, does it meet the requirements specified in the following references? (Reference: [29 CFR 1910.109](#) and [119](#))

(5) **Chemical Hygiene Program** (laboratories) (Reference: [29 CFR 1910.1450](#)).

(6) **Respiratory Protection Program.** Does the DLA organization have operations that require the use of respiratory protection? If so, how are the employees fit tested and trained, and are they part of the medical surveillance program? (Reference: [29 CFR 1910.134](#) and [DLAI 6055.1, enclosure 5](#))

(7) **Bloodborne Pathogen Program.** Does this organization have occurrences that require the implementation of a bloodborne pathogen program? If so, is there a written program and what are the procedures to document employee involvement and their associated training? (Reference: [enclosure 14](#) and [29 CFR 1910.1030](#))

(8) **Lock Out/Tag Out.** Does this organization have energy sources that require a Lock Out/Tag Out program? If so, has the program been established in writing and what procedures are in place to document employee participation and training? (Reference: [29 CFR 1910.147](#) and [1910.331-335](#))

(9) **Ergonomics.** Does this organization have operations or conditions that require an Ergonomics Program? Is there a written Ergonomics Program for this organization and what are the procedures that are used to illustrate the organization's compliance? (Reference: [DoDI 6055.1, enclosure 6](#); and [DLAI 6055.1, enclosure 8](#))

i. **Radiation Protection.** Has a Radiological Protection Program been established and implemented where required? (Reference: [DLAR 6055.4](#))

j. **Emergency Action Plan.** If there are more than ten (10) employees, is there a written emergency plan available at the workplace? Check the plan to ensure all elements are included as stated in the OSHA regulations (Reference: [29 CFR 1910.38\(a\) \(2\)](#)).

k. **Lead Exposure.** Does this organization have lead sources that are controlled or not controlled? What measures are used to eliminate exposures to lead? Are there written procedures for employees working with lead, and are they part of the medical surveillance and respiratory protection programs? (Reference: [29 CFR 1910.1025\(c\) \(3\)](#); [29 CFR 1926.62](#))

3. Tour portions of the facility if time allows.

4. Prepare and provide an exit briefing for the commander/administrator or their designated representative.

F. FOLLOW-UP ACTIONS

1. Prepare report and forward to the commander or the administrator of the organization evaluated requesting action to correct findings

a. For violation of regulations, instructions, or directives, "findings" and "recommendations" will be provided in the report.

b. For SOH Program enhancement and good practice for building a comprehensive SOH Program, "observations" and "suggestions" will be provided in the report.

2. The organization should provide a response to the report within 45 days from the date of the report.

G. VISIT TO A SECONDARY LEVEL ACTIVITY

1. Conduct an entrance briefing with the commander.

2. Visit with the host SOHO and discuss interface with our safety representative. Ask what, in their opinion, we might do at our level to foster good relations.

3. Talk to at least two employees at random. Ask if they know the name of their local safety person?

4. Meet with local employee union representatives, if any, to determine relationship with the local SOHO. Determine if union representative has received safety training.

5. Is there a PLFA Safety letter posted, and is there a local policy letter?

6. Check official bulletin boards for the DoD Safety Poster (DD Form 2272) and look to see if it has been completed properly.

7. Councils & Committees

a. Determine if anyone from the activity represents DLA on the host installation's Safety and Health Council.

b. Is there a local (DLA) Safety committee? If yes, do they keep minutes and forward a copy to the PLFA Council?

8. How are mishaps being entered into SHIRS?

a. Entered directly in the SHIRS database, or

b. On a hard copy of DLA Form 1591 that is forwarded to the local safety office.

9. Worksite inspections

a. Review the annual worksite inspection plan for inclusion of all worksites and review at least two reports for content

b. Determine what methods are used to correct deficiencies

c. What type of follow-up is accomplished to ensure completion of corrective actions.

10. Review ISAs with host to determine extent of safety support, medical support (physical evaluations, etc.) and ambulance service to be provided by the host.

11. Hazard log

a. Review the local hazard log for quality of processing and completeness of corrective actions taken. Is this information placed in SHIRS or is a hard copy log used?

b. Review the hazard abatement log. Are hazards not abated after 30 days placed on this log?

12. Determine if the supervisory/manager performance standards include a statement of safety responsibility as a critical element. See examples. Reference [DLAD 1434.1](#) and [DLAI 1434.1](#)

13. Have comprehensive periodic evaluations of potential health hazards been initiated and/or updated?

a. If yes, provide date(s) of last evaluations/surveys.

b. What sampling has been performed? Provide Dates.

c. Is there a need for respiratory protection or other PPE? If yes, are there appropriate exposure monitoring, training, fit testing and other records to document the need?

14. Review the local confined space policy and check for problems.

15. Check hazardous commodities storage area (mission and/or service stock) and ask one or two employees at random if they:

a. Know where the material safety data sheets (MSDSs) are located. Do employees know how to use the MSDS?

b. Has health hazard training been conducted and documented?

c. Ask the manager or supervisor for a list of hazardous commodities.

16. Visit portions of the facility if time allows.

17. Provide an exit briefing with the commander or representative, if the commander desires.

**PART II
SAFETY AND HEALTH PROGRAM
EVALUATION PROTOCOL CHECKLIST**

ACTIVITY: EVALUATOR(s): DATE:				
<u>ADMINISTRATIVE REQUIREMENTS</u>	YES	NO	N/A	NOTES
1. Is there an Organization Chart showing the Safety Office location? Enclosure 2, paragraph E.2.a.(1) & 29 CFR 1960.6(b)				
2. Mission and Function Statement Enclosure 2, paragraph E.2.a.(3) & 29 CFR 1960.6(b)(3)				
<ul style="list-style-type: none"> • Is there a statement for safety and health? 				
<ul style="list-style-type: none"> • Does it include all necessary program functions? 				
3. Safety and Health Council Meetings Enclosure 2, paragraph E.2.a.(4) ; DoDI 6055.1, paragraph E3.10.1.3 ; DLAI 6055.1, paragraph E.3.				
<ul style="list-style-type: none"> • Is there a Council established? 				
<ul style="list-style-type: none"> • Does it meet quarterly? 				
<ul style="list-style-type: none"> • Are there minutes of the meetings? 				
4. Policy Guidance Enclosure 2, paragraph E.2.a.(5) & 29 CFR 1960.12(b) <ul style="list-style-type: none"> • Supplement to HQ Policy guidance • Letters • Regulations • Directives • Are employees informed annually about location of technical information? 				

	YES	NO	N/A	NOTES
5. Is there a Safety and Health Plan? Enclosure 2, paragraph E.2.a.(6) ; DLAI 6055.1, paragraph F.1.c.(3) ; 29 CFR 1960.6(b)(4)				
6. Review of ISAs, MOUs Contracts Enclosure 2, paragraph E.2.a.(7) ; DLAI 6055.1, paragraph E.8.				
• Are there ISAs, MOUs, or contracts?				
• If so, are requirements being accomplished?				
7. DoD POSTER – Form 2272, DoD OSHA Enclosure 2, paragraph E.2.a.(8) ; DoDI 6055.1, paragraph E3.1.6.2 ; 29 CFR 1960.12(b)				
8. Resources Enclosure 2, paragraph E.2.a.(9) ; DoDI 6055.1, paragraph 5.2.3 ; 29 CFR 1960.7				
• Sufficient resources to support the program?				
• Adequate staffing to conduct program?				
• Adequate equipment for:				
• IH testing and investigation?				
• ADP?				
9. Education and Training Policy Enclosure 2, paragraph E.2.d ; 29 CFR 1960.54 - .60				
• Is there a Training Plan and does it include all necessary OSHA training requirements?				
• Safety Monitor				
• Supervisor Safety				
• New Employee Safety Orientation				
• Hazard Communication				
• PPE Certification				
• Respirator				

	YES	NO	N/A	NOTES
• Hearing Conservation				
• HM/HW Handlers Initial Refresher				
• Bloodborne Pathogen				
• Confined Space				
• Ergonomics				
• First Aid				
• CPR				
• Forklift Operator (initial & refresher)				
• Crane Operator (initial & refresher)				
• Spill Response				
• Union Rep Safety Training				
• Other				
10. Do supervisory performance standards include a statement of safety responsibility? Enclosure 2, paragraph E.2.a.(10) ; 29 CFR 1960.11 ; DLA Directive 1434.1 and DLA Instruction 1434.1				
11. OWCP/Safety Interface Enclosure 2, paragraph E.2.b.(1)				
• Is there a working relationship between OWCP Coordinator and Safety?				
• Open communication?				
• Is the coordinator on line with SHIRS?				

	YES	NO	N/A	NOTES
12. Union Interface Enclosure 2, paragraph E.2.b.(2)				
• Is there good interaction between Safety and Union?				
• Does the Union Representative attend Safety and Health Council meetings?				
• Is training provided that is similar to safety training for supervisors?				
13. Do Employees have access to their exposure and medical records? Enclosure 2, paragraph E.2.g.(1)(b); 29 CFR 1910.1020				
<u>HAZARD DETECTION, REPORTING AND ABATEMENT</u>				
14. Mishap Reporting and Investigation Enclosure 2, paragraph E.2.e.; DoDI 6055.7; 29 CFR 1960.29				
• Any fatality or hospitalization of 5 or more days?				
• Accuracy				
• Completeness.				
• Corrective actions completed.				
• Management involvement.				
15. Safety and Health Inspections Enclosure 2, paragraph E.2.c.(2); DoDI 6055.1 paragraph E3.4.2; 29 CFR 1960.26				
• Written inspection procedures				
• Schedule of Inspections				
• Are inspections conducted timely?				

	YES	NO	N/A	NOTES
<ul style="list-style-type: none"> Written Inspection Reports <ul style="list-style-type: none"> - Are RACs used? - Notices prepared and posted? 				
<ul style="list-style-type: none"> Are Follow-up actions conducted? 				
16. Hazard Report Log Enclosure 2, paragraph E.2.c.(1); paragraph E.10.a.(4); 29 CFR 1960.28				
<ul style="list-style-type: none"> Is the SHIRS hazard log used? <ul style="list-style-type: none"> - DLA Form 1404 - Locally developed form? 				
<ul style="list-style-type: none"> Is hazard reporting publicized with appeal rights? 				
<ul style="list-style-type: none"> Are replies submitted timely? 				
17. Hazard Abatement Log Enclosure 2, paragraph E.2.c.(1); paragraph E.10.a.(4); DoDI 6055.1 paragraph E.3.7.2; 29 CFR 1960.30				
<ul style="list-style-type: none"> Is there a hazard abatement log? 				
<ul style="list-style-type: none"> Is it current? 				
<u>INDUSTRIAL HYGIENE AND OTHER TECHNICAL REQUIREMENTS</u>				
18. Industrial Hygiene surveillance Comprehensive Periodic Evaluations Enclosure 2, paragraph E.2.g.(1)(a); DoDI 6055.5				
<ul style="list-style-type: none"> IH Exposure Data availability <ul style="list-style-type: none"> - Occupations with hazardous exposure - Location of hazard - Type of medical surveillance required - PPE required 				

	YES	NO	N/A	NOTES
19. Health Hazard Education Enclosure 2, paragraph E.2.g.(5) ; DoDI 6055.5				
<ul style="list-style-type: none"> Are employees working in hazardous areas being trained on hazards associated with their jobs? 				
<ul style="list-style-type: none"> Is the training documented? 				
20. Immunizations Enclosure 2, paragraph E.2 g.(6) ; Enclosure 7, paragraph 5.e. ; DoDI 6205.2				
<ul style="list-style-type: none"> Are they provided at government expense when they are needed? 				
<ul style="list-style-type: none"> Is there written guidance explaining policy? 				
21. Emergency Medical Treatment Enclosure 2, paragraph E.2.b.(7) ; Enclosure 7, paragraph 5.a.				
<ul style="list-style-type: none"> How is this care provided and by what facility for job-related injuries and illnesses? 				
22. Research and Development Enclosure 2, paragraph E.2.g.(8) ; DoDI 6055.5, paragraph 6.5				
<ul style="list-style-type: none"> Has any research or development been done, when needed, to assess the effects and impact of specific conditions, etc.? 				
23. Records Management Enclosure 2, paragraph E.2.g.(9) ; DoDI 6055.5 ; 5 U.S.C. 552a				
<ul style="list-style-type: none"> Are civilian employee medical records maintained in accordance with DoDI 6055.5 				
<ul style="list-style-type: none"> Are there any military medical records? 				
<ul style="list-style-type: none"> Are there Industrial Hygiene Surveillance Records? 				

	YES	NO	N/A	NOTES
<ul style="list-style-type: none"> Is there comprehensive baseline IH data for each workplace and updates? 				
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Are employees or employee representatives permitted access to their workplace records? 				
<ul style="list-style-type: none"> Are IH workplace monitoring and surveys retained for a minimum of 40 years? 				
24. Hazard Communication Program Enclosure 2, paragraph E.2.h.(3) ; 29 CFR 1910.1200 ; DLAI 6055.1, Enclosure 11 ; DoDI 6050.5				
<ul style="list-style-type: none"> Is there a written program? 				
<ul style="list-style-type: none"> Is there an inventory of chemicals/HM? 				
<ul style="list-style-type: none"> MSDS accessibility? 				
<ul style="list-style-type: none"> Is there proper labeling? 				
<ul style="list-style-type: none"> How is training provided and documented? 				
25. Personal Protective Equipment Program Enclosure 2, paragraph E.2.f ; Enclosure 10 ; 29 CFR 1910.132				
<ul style="list-style-type: none"> Is there a written, publicized program? 				
<ul style="list-style-type: none"> Have areas been identified where PPE is required? 				
<ul style="list-style-type: none"> Are these identifications based on IH surveys? 				
<ul style="list-style-type: none"> Have assessments of identified workplaces been certified in writing? 				
<ul style="list-style-type: none"> Have employees working in these areas been identified? 				
<ul style="list-style-type: none"> Is PPE provided where required with no expense to employees? 				

	YES	NO	N/A	NOTES
<ul style="list-style-type: none"> • Have employees received certified PPE Training? 				
<ul style="list-style-type: none"> • Is the training documented and is it with a statement demonstrating employees understand the training? 				
<ul style="list-style-type: none"> • Does SOHO approve type of PPE used? 				
26. Respiratory Protection Program Enclosure 2, paragraph E.2.h.(6) ; DLAI 6055.1, Enclosure 5 ; 29 CFR 1910.134				
<ul style="list-style-type: none"> • Is there a written program/SOP? 				
<ul style="list-style-type: none"> • Procedures for selection and issuance? 				
<ul style="list-style-type: none"> • Training for employees and supervisors? 				
<ul style="list-style-type: none"> • Medical evaluations prior to use? 				
<ul style="list-style-type: none"> • Maintenance and inspection of respirators? 				
27. Confined Space Enclosure 2, paragraph E.2.h.(2) ; DLAI 6055.1, Enclosure 9 ; 29 CFR 1910.146				
<ul style="list-style-type: none"> • Is there a written Program/SOP? 				
<ul style="list-style-type: none"> • Are there records that document correct entry? 				
<ul style="list-style-type: none"> • Is there training & certification, and is it provided? 				
28. Hearing Conservation Program Enclosure 2, paragraph E.2.h.(1) ; Enclosure 3 ; DoDI 6055.12				
<ul style="list-style-type: none"> • Are noise hazards areas identified? 				
<ul style="list-style-type: none"> • Are there any records to document noise surveys? (e.g. DD Form 2214)? 				
<ul style="list-style-type: none"> • Are employees identified and trained? 				

	YES	NO	N/A	NOTES
<ul style="list-style-type: none"> Are hearing tests conducted in an “approved” Audiometric test booth? 				
29. Blood-Borne Pathogen Enclosure 2, paragraph E.2.h.(7) ; Enclosure 14 ; 29 CFR 1910.1030				
<ul style="list-style-type: none"> Are there official designated first responders for emergencies? 				
<ul style="list-style-type: none"> How close is the nearest medical facility? 				
<ul style="list-style-type: none"> Is there an Exposure Control Plan? 				
<ul style="list-style-type: none"> Is the information of the blood-borne pathogen program documented? 				
<ul style="list-style-type: none"> Are there exposure records? 				
<ul style="list-style-type: none"> Are there any training records and are they current? 				
30. Medical Surveillance Enclosure 2, paragraph E.2.g.(1)(b) ; 29 CFR 1910.120(f) ; 1910.1000-series chemical-specific standards; DoDI 6055.5 ; DoD 6055.5-M ; 29 CFR 1910.1020				
<ul style="list-style-type: none"> Is medical surveillance provided as required? 				
<ul style="list-style-type: none"> Is it based on exposure data from comprehensive IH evaluations? 				
<ul style="list-style-type: none"> Are medical records of employees posted with specific exposure and medical surveillance data? 				
<ul style="list-style-type: none"> Do employees have access to their medical and hazardous exposure records? 				
31. Chemical Hygiene Enclosure 2, paragraph E.2.h.(5) ; 29 CFR 1910.1450				
<ul style="list-style-type: none"> Is there a chemical lab? 				

	YES	NO	N/A	NOTES
<ul style="list-style-type: none"> If so, has a Chemical Hygiene Officer been designated? 				
<ul style="list-style-type: none"> Is there a written and implemented Chemical Hygiene Plan? 				
32. Ergonomics Enclosure 2, paragraph E.2.h.(g) ; Enclosure 8 ; DoDI 6055.1, Enclosure 6				
<ul style="list-style-type: none"> Is there a written Ergonomics Program? 				
<ul style="list-style-type: none"> If so, have problem areas been identified and proper controls initiated? 				
33. Lock-Out/Tag-Out Program Enclosure 2, paragraph E.2.h.(8) ; 29 CFR 1910.147 and 29 CFR 1910.331-335				
<ul style="list-style-type: none"> Are there energy devices that require Lock-Out/Tag-Out? 				
<ul style="list-style-type: none"> Is there a written Program? 				
<ul style="list-style-type: none"> Are there training documents? 				
34. Process Safety Management (PSM) Program. Enclosure 2, paragraph E.2.h.(4) ; 29 CFR 1910.109 and 29 CFR 1910.119				
<ul style="list-style-type: none"> Is there a need for Written Program? 				
<ul style="list-style-type: none"> Are the Chemicals identified and documented? 				
35. Radiation Protection Program Enclosure 2, paragraph E.2.i ; DLAR 6055.4				
<ul style="list-style-type: none"> Where required, has the commander designated a Radiation Protection Officer in writing? 				
<ul style="list-style-type: none"> Has a Radiological Protection Program been established and implemented where required? 				

	YES	NO	N/A	NOTES
<ul style="list-style-type: none"> Are records of any exposures to regulated radiation retained by licensee? 				
36. EMERGENCY ACTION PLAN Enclosure 2, paragraph E.2.j; 29 CFR 1910.38				
<ul style="list-style-type: none"> Is there a written plan at the work place? 				
<ul style="list-style-type: none"> Is the written plan available to the employees? 				
<ul style="list-style-type: none"> Does it include the necessary elements as stated in 29 CFR 1910.38 (a) (2) ? 				
37. LEAD EXPOSURE Enclosure 2, paragraph E.2.k; 29 CFR 1910.1025(c)(3); 29 CFR 1926.62				
<ul style="list-style-type: none"> Are there sources of lead? 				
<ul style="list-style-type: none"> If so, are there written procedures for employees who work with lead? 				
<ul style="list-style-type: none"> Are employees provided with personal protective equipment? 				
<ul style="list-style-type: none"> Are the employees on the Medical Surveillance Program? 				
SUGGESTIONS / OBSERVATIONS / ADDITIONAL COMMENTS				

Hearing Conservation

1. DLA will protect its employees using [DoDI 6055.12, DoD Hearing Conservation Program \(reference 13\)](#).

a. DLA will provide noise reduction measures including hearing protection, audiometric testing, worker training, and other worker protections for noise exposures at or above 85 dBA as an 8-hour time-weighted average, or impulse noise sound pressure levels of 140 decibels (dB) peak.

b. DLA will use the 3 dB exchange rate for determining worker exposure to hazardous noise. [interpretation](#)

c. All hearing conservation data will be entered into the Defense Occupational Health Readiness System (DOHRS) Hearing Conservation database.

2. Each DLA organization, which conducts or has employees in operations involving occupational exposure to hazardous noise, shall establish and maintain a comprehensive and effective Hearing Conservation Program. As a minimum, a hearing conservation program will include:

- a. noise measurements and analysis,
- b. a procedure to ensure hazardous noise areas and equipment are appropriately posted with signs and labels,
- c. noise abatement,
- d. use of personal hearing protection,
- e. employee education,
- f. audiometric testing and follow-up medical evaluation and consultation,
- g. supporting documentation and appropriate access to records, and
- h. other key elements that ensure compliance with DoDI 6055.12 (reference 13).

Mishap and Hazard Investigation and Reporting

1. PURPOSE. Mishap (accident) and hazard reporting provides the detailed information essential to preventing future accidents. This enclosure provides procedures for collecting the needed information while minimizing time required for administrative tasks.

2. POLICY. DLA reporting will be accomplished in accordance with DoD Instruction 6055.1 (reference 3) and [DoD Instruction 6055.7](#) (reference 10) using the DLA Safety and Health Information Reporting System (SHIRS). Regardless of exceptions which may be found in DoDI 6055.7, all mishaps that occur in DLA will be recorded and reported using SHIRS.

3. MISHAP INVESTIGATION

a. Purpose of Investigation. Mishap investigation is important and necessary if future mishaps of a similar nature are to be prevented. A mishap investigation is not an attempt to arrive at a finding of guilt or innocence. On the contrary, it seeks to determine the causes of mishaps by determining the elements and sources from which the mishaps develop. Corrective measures may then be determined by analyzing the causal factors, making recommendations for their elimination, and instituting corrective measures. Mishap investigation also assists in developing "safety awareness" and knowledge of safe conditions and safe work methods.

b. Conducting Investigations. Investigations conducted by safety and health personnel of the host base, Military Services, or other related organizations may be used to satisfy this requirement. It is desirable that, when resources are available, all mishaps should be investigated by safety and health personnel. These investigation requirements do not relieve supervisory personnel of the responsibility to complete the appropriate portions of the mishap report forms. The report forms will be reviewed by appropriate management personnel and corrective action accomplished and documented in accordance with the additional instructions for the mishap report form.

c. Investigation Procedures. Personnel conducting mishap investigations should recognize that nearly all mishaps are the result of multiple system and/or personnel performance failure. Therefore, all of the physical evidence and the chronology of events related to the mishaps should be documented and carefully studied, along with the relative regulatory guidance, to ensure that all causes of the mishap are identified and recorded. Investigators should use the following questions as a guideline to develop the evidence necessary to identify the mishap cause(s).

- (1) Information related to injured/operator personnel.
 - (a) Were personnel physically qualified?
 - (b) Were personnel trained to perform the job assignment?
 - (c) Were personnel qualified/certified/licensed to operate the equipment in use?
 - (d) Were personnel familiar with the operating instruction, standards, and regulation related to the job?
 - (e) Was the operating instruction, safety standard, and/or regulation followed?
 - (f) Was personal protective equipment required? Used?
 - (g) Was sufficient time allocated to accomplish the task safely?
- (2) Information related to supervisory and management personnel.
 - (a) Has an operating instruction been published for the employee to follow?
 - (b) Do the operating instructions contain safety standards and regulation requirements?

- (c) Were the operating instructions, use of standards, and compliance with regulations enforced?
- (d) Does the employee-supervisor-management relationship provide for a free exchange of mishap prevention information?
- (e) Has management provided the supervisor sufficient resources to accomplish the assigned workload?
- (3) Information related to the worksite.
 - (a) Is the lighting sufficient?
 - (b) Is the work surface free of hazards?
 - (c) Is the noise level above 85 dBA?
 - (d) Is the worksite arranged to eliminate mishap producing motions?
 - (e) Was the weather a factor?
- (4) Information related to the equipment, if applicable.
 - (a) Is the equipment properly designed for the job?
 - (b) Has the equipment been inspected and certified?
 - (c) Is the equipment properly used, placed, or arranged?
 - (d) Is the equipment properly guarded?
 - (e) Was there equipment failure?
 - (f) Was equipment properly maintained?
- (5) Information related to OSH standards. Was an OSH standard violated?

4. MISHAP REPORTING PROCEDURES. All operational details relative to mishap reporting in DLA will be found in SHIRS where online help is readily available through a series of "help screens/popups." Guidance is contained in the Safety and Health section of SHIRS entitled "Getting Started - What Is Reportable." Guidance is also included in this section on "Who Reports" and "What You Need." Daily operating guidance can also be found in the SHIRS Users Manual which provides printed examples of SHIRS screens and instructions on "how to" use SHIRS. Where SHIRS is not available, DLA activities will record mishaps on DLA Form 1591, "Mishap Report" (figure 4-4) and forward the completed form to the SOHO for entering into SHIRS.

5. SPECIAL REPORTING OF SERIOUS MISHAPS. In addition to the recording of all mishaps in SHIRS, DLA activities will immediately report serious mishaps to the HQ DLA SOHO. Activities may report by telephone or fax so that the HQ DLA SOHO is able to report the accident to the Assistant Deputy Under Secretary of Defense (Force Protection) (ADUSD(FP)) within 48 hours of the accident's occurrence.

- a. Serious mishaps include:
 - (1) fatalities
 - (2) injury/illness resulting in permanent total disability
 - (3) accident damages of \$1 million or more
 - (4) DoD aircraft destroyed
 - (5) inpatient hospitalization of three or more personnel
- b. Special reporting of serious mishaps will include:
 - (1) Date and local time of accident
 - (2) Location
 - (3) Extent of injuries and property damage
 - (4) Narrative report of the circumstances of the accident
 - (5) Any action(s) taken by DLA as a result of the accident

6. HAZARD REPORTING PROCEDURES. DLA personnel will also utilize SHIRS to record and track hazard reports, hazard abatement reports, hazard notices, and inspection reports required elsewhere in this Instruction. Employees or other parties may report hazards using DLA Form 1404, "Hazard Report" (figure 4-3), or equivalent information. The assigned SOHO will enter this information into SHIRS.

7. HAZARD ABATEMENT TRACKING.

- a. All hazards will be reviewed and assigned a risk assessment code (RAC).
- b. RAC 1, 2, and 3 hazards will be entered and tracked in the DLA Safety and Health Information and Reporting System (SHIRS). RAC 4 and 5 hazards may also be included. Where SHIRS is not available, DLA personnel will track hazards using the DLA Form 1404a, "Hazard Report Log" (figure 4-1), or local procedure which records the same information, and forward monthly to the SOHO for entering into the SHIRS.
- c. Abatement Log. DLA personnel will track RAC 1, 2, and 3 hazards unabated after 30 days locally using the DLA Form 1691, "Hazard Abatement Log" (figure 4-2), or equivalent local procedure. Personnel will notify affected employees of these hazards, and of interim and final corrective measures to minimize their risk. Local organizations will forward abatement log information monthly to the SOHO for entering into the SHIRS.

Respiratory Protection

1. Each PLFA that conducts operations or has employees in operations requiring respiratory protection will develop and implement a written respiratory protection program that meets the requirements of [29 CFR 1910.134, Respiratory Protection](#) (reference 21). A suitably trained program administrator must administer the program. Supervisors shall provide employees with required or optional use respiratory protection whether working at DLA or at contractor facilities. The program shall be updated as necessary to reflect those changes in workplace conditions that affect respirator use. The SOHO shall review and approve written respiratory protection programs.

2. Responsibilities

a. Respiratory Protection Program Administrator

- (1) administers or oversees the respiratory protection program, and
- (2) conducts the required evaluations of program effectiveness.

b. Supervisors

- (1) know the hazards in their areas that require respiratory protection,
- (2) know the types of respirators that need to be used,
- (3) ensure the respirator program and worksite specific procedures are followed,
- (4) enforce the wearing of respirators where they are required,
- (5) ensure that employees receive training and medical evaluations when necessary,
- (6) coordinate annual re-training, and
- (7) notify the SOHO of any problems with respirator use, or any changes in work processes that would change airborne contaminant levels and resulting respiratory protection requirements.

c. Employees

- (1) participate in all required respiratory protection training,
- (2) wear the respirator in accordance with the program policies and worksite specific procedures,
- (3) properly maintain their respiratory protection equipment, and
- (4) report any malfunctions or concerns to their supervisor.
- (5) undergo required fit testing or medical surveillance

d. SOHOs shall ensure each workplace is evaluated for respiratory hazards.

3. Hazard Assessments

a. Workplace Evaluations

(1) Each workplace will be evaluated for respiratory hazards. This evaluation shall include a reasonable estimate of employee exposures to respiratory hazard and an identification of the contaminant's chemical state and physical form. Where the employee's exposure cannot be identified or reasonably estimated, the atmosphere shall be considered to be Immediately Dangerous to Life and Health (IDLH). Once a respiratory hazard has been identified, the work area must be monitored for any changes in the hazard or for new hazards. Changes in work processes, substitution of materials, or changes in the ventilation of an area may necessitate re-testing. Supervisors are responsible for monitoring day-to-day operations and reporting changes to the SOHO.

(2) Controlling airborne hazards. When controlling airborne hazards, engineering and administrative controls will be considered first as a means to reduce the hazards. Engineering controls can include enclosure, substitution, process modification, and ventilation. Administrative controls include

scheduling changes to reduce time spent in contaminated areas. When engineering and administrative controls do not sufficiently reduce exposure to levels below occupational exposure limits, respirators are required.

b. Respiratory Hazards. There are two main types of respiratory hazards: oxygen deficiency and airborne contaminants. The main types of airborne contaminants are:

(1) dusts: particles, released during work operations such as grinding and sawing.

(2) mists: particles of liquid, released during operations such as spray painting.

(3) vapors: gaseous forms of a liquid, such as paint solvents.

(4) fumes: vaporized condensed metals, as present in welding operations.

(5) gases: such as nitrogen, methane, carbon monoxide.

4. Selection and Use of Respiratory Protection. Employees shall wear only respirators that have been selected, fit tested, and approved for use for the respiratory hazards.

a. General selection criteria. Respirators will be selected based on the respiratory hazards to which the employee is exposed, and the workplace and user factors that affect performance.

(1) Only NIOSH approved respirators will be used.

(2) Single strap disposable comfort masks are not approved respirators.

(3) An employee shall wear only a respirator that has been fit tested and approved for the employee and the hazards of the exposure. Respirator types, models, sizes, and cartridges are not interchangeable.

(4) The following factors are to be considered when determining the proper respiratory protection:

(a) Employee exposure (e.g., concentration, route of exposure). If the employee exposure cannot be identified or estimated, then the atmosphere must be considered IDLH.

(b) Physical form and chemical state of the contaminant.

(5) Limitations of Air Purifying Respirators

(a) Air purifying respirators shall not be used in oxygen deficient atmospheres, IDLH atmospheres, or unknown atmospheres. All confined spaces shall be considered IDLH unless proven otherwise.

(b) Respirator types, models, and sizes are not interchangeable. An employee shall only wear a respirator that has been fit tested and approved for the employee's use.

(c) Cartridges and filters are specific to certain hazards. Use the cartridge approved for the task. Do not interchange manufacturer's cartridges or filters.

(d) Half mask and full-face respirators are limited in the chemical concentrations for which they can be used. Review the respirator cartridge's Maximum Upper Limit to determine if you have the proper level of protection.

(e) Anything that breaks the seal of a respirator will reduce its effectiveness. Facial hair, temple bars of glasses and head coverings are not to be worn. Corrective lenses can be fitted inside a full-face respirator with a special insert kit.

b. Particulates. For protection against particulates, one of the following respirators shall be provided.

(1) An atmosphere supplying respirator,

(2) An air purifying respirator equipped with a high efficiency N, R or P series filters certified by NIOSH. (Note: R- or P-series filters can be used for protection against oil or non-oil aerosols. N-series filters should be used only for non-oil aerosols.),

(3) An air purifying respirator equipped with a filter certified for particulates by NIOSH,

(4) For contaminants consisting primarily of particulates with a mass median aerodynamic diameter (MMAD) of at least 2 micrometers, an air purifying respirator with any filter certified for particulates by NIOSH.

c. Gases and vapors. For protection against gases and vapors, one of following respirators shall be provided:

(1) An atmosphere supplying respirator.

(2) An air purifying respirator that is either equipped with a chemical cartridge that has an end of service life indicator (ESLI) certified by NIOSH for the contaminant. Note: If there is no appropriate ESLI, then a replacement schedule must be in place for cartridges and filters based on information that will assure the cartridges are changed before their end of service life. The replacement schedule must be included in the worksite specific instructions.

(3) A chemical cartridge respirator which meets the requirements of Table 5-1 below.

Table 5-1 - Chemical Cartridge Respirator Requirements

Type	Capabilities	Fit Test	Limitations
Air Purifying, Chemical Cartridge, Half-face	Chemical Specific Cartridge APF=10	Qualitative	Not for use in atmospheres with concentrations above 10 times the PEL. Not for use for any chemical not listed on the cartridge, IDLH or unknown atmospheres.
Air Purifying, Chemical Cartridge, Full-face	Chemical Specific Cartridge APF=50	Qualitative or quantitative	Qualitative fit testing is not approved for respirator use in atmospheres above 10 times the PEL. Not for use for any chemical not listed on the cartridge, IDLH or unknown atmospheres.
Powered Air Purifying, Chemical Cartridge, Full-face	Chemical Specific Cartridge APF=50	Qualitative or quantitative	Not for use for any chemical not listed on the cartridge, IDLH or unknown atmospheres.

d. IDLH. Atmospheres will be considered IDLH when airborne chemicals are above IDLH levels, for oxygen deficiency, and where hazard levels cannot be determined. Oxygen-deficient atmospheres shall be considered IDLH unless it is demonstrated that, under all foreseeable conditions, the oxygen concentration can be maintained above the concentration specified in Table 5-2. Any atmosphere-supplying respirator may be used for oxygen levels between the IDLH and 19.5 percent oxygen. One of the following respirators shall be provided for protection in IDLH atmospheres.

(1) A full facepiece pressure demand self-contained breathing apparatus (SCBA) certified by NIOSH for a minimum service life of thirty minutes, or

(2) A combination full facepiece pressure demand supplied-air respirator (SAR) with auxiliary self-contained air supply.

(3) Respirators provided only for escape from IDLH atmospheres shall be NIOSH-certified for escape from the atmosphere in which they will be used.

Table 5-2 - IDLH Oxygen-deficient Atmospheres by Altitude

Altitude (ft)	IDLH level (% oxygen) ¹
Less than 3001	16.0
3001 - 4000	16.4
4001 - 5000	17.1
5001 - 6000	17.8

6001 - 7000	18.5
7001 - 8000	19.3

e. Working in IDLH atmospheres. The supervisor shall ensure that:

- (1) One employee or, when needed, more than one employee is located outside the IDLH atmosphere;
- (2) Visual, voice, or signal line communication is maintained between the employees in the IDLH atmosphere and the employees located outside the IDLH atmosphere;
- (3) The employees located outside the IDLH atmosphere are trained and equipped to provide effective emergency rescue;
- (4) The supervisor or designee is notified before the employees located outside the IDLH atmosphere enter the IDLH atmosphere to provide emergency rescue;
- (5) The supervisor or designee authorized to do so by the supervisor, once notified, provides necessary assistance appropriate to the situation;
- (6) Employees located outside the IDLH atmospheres are equipped with:
 - (a) Pressure demand or other positive pressure SCBAs, or a pressure demand or other positive pressure supplied-air respirator with auxiliary SCBA; and either
 - (b) Appropriate retrieval equipment for removing the employees who enter these hazardous atmospheres where retrieval equipment would contribute to the rescue of the employees and would not increase the overall risk resulting from entry; or
 - (c) Equivalent means for rescue.

f. Procedures for interior structural firefighting

- (1) Follow the procedures for IDLH atmospheres
- (2) At least two employees will enter the IDLH atmosphere and remain in visual or voice contact with one another at all times.
- (3) At least two employees are located outside the IDLH atmosphere.
- (4) All employees engaged in interior structural firefighting use SCBAs.

g. Leaving the Respirator Use Area

- (1) Supervisors shall ensure that employees leave the respirator use area:
 - (a) to wash their faces and respirators as necessary to prevent eye or skin irritation.
 - (b) if they detect vapor or gas breakthrough, changes in breathing resistance, or leakage of the facepiece.
 - (c) to replace the respirator or the filter cartridges or canisters.
- (2) A defective respirator must be replaced or repaired before returning to the work area.

h. Voluntary Use of Respirators. Where respirators are not required, but employees wish to voluntarily wear respirators:

- (1) Employees will be allowed to use respirators voluntarily if the respirator itself will not create a hazard.
- (2) Employees whose only use of a respirator is the voluntary use of a dust mask (filtering facepiece) are not subject to the requirements of the written program.
- (3) Employees voluntarily wearing respirators other than dust masks are subject to the requirements of this program, including medical evaluations, training, and maintenance procedures.
- (4) For voluntary users, fit tests are encouraged, but not required.
- (5) Employees voluntarily wearing respirators will be provided a copy of the information contained in [Appendix D to 29 CFR 1910.134, "Information for Employees Using Respirators When Not Required Under the Standard."](#)

5. Medical Evaluation

a. Initial Evaluation

(1) Every employee must be medically evaluated prior to fit testing and initial use of a respirator.

(2) A physician or other licensed health care professional shall conduct medical evaluations.

(3) Medical evaluations shall consist of either a medical questionnaire or an initial medical examination that obtains the same information as the questionnaire. The OSHA Respirator Medical Evaluation questionnaire is contained in [Appendix C to 29 CFR 1910.134](#) (reference 21). The requirements of the questionnaire are mandatory.

(4) Medical questionnaires and examinations shall be administered confidentially and during normal working hours.

b. Follow-up Medical Examinations. Follow-up medical examinations are necessary if an employee gives a positive response to any of the questions numbered 1 through 8 in section 2 of the questionnaire. The follow-up medical examination shall include any medical tests, consultations or diagnostic procedures that the physician or other licensed health care professional deems necessary to make a final determination.

c. Supplemental Information for the Physician or Other Licensed Health Care Professional. The following information must be supplied to the physician or other licensed health care professional before a recommendation is made:

- (1) type and weight of the respirator to be used,
- (2) duration and frequency of use,
- (3) expected physical effort,
- (4) additional protective clothing and equipment to be worn,
- (5) temperature and humidity that may be encountered, and
- (6) a copy of the written program and the regulation.

d. Medical Determination

(1) The supervisor must obtain a written recommendation from the physician or other licensed health care professional on whether or not the employee is medically able to use the respirator. The recommendation shall include only the following information:

- (a) any limitations on respirator use related to the medical condition of the employee or workplace conditions including whether the employee is medically able to wear the respirator;
- (b) the need, if any, for a follow-up medical examination; and
- (c) a statement that the physician or other licensed health care professional has provided the employee with a copy of the recommendation.

(2) If the physician or other licensed health care professional finds an employee cannot use a negative pressure respirator, a powered air-purifying respirator will be provided, if suitable to the work conditions.

e. Additional Medical Evaluations. Additional medical evaluations shall be provided if:

- (1) an employee reports medical signs or symptoms related to the ability to use a respirator;
- (2) a physician or other licensed health care professional, supervisor, or the Safety and Occupational Health Official deems an employee needs re-evaluation;
- (3) Information from the program, observations during fit tests, or evaluations indicate the need for re-evaluation; or
- (4) changes in the workplace conditions result in increased physiological burden on the employee.

f. Employee Access to Medical Evaluations. The employee shall receive a copy of the physician or other licensed health care professional's recommendation. The employee shall have an opportunity to discuss the questionnaire and examination with the physician or other licensed health care professional.

6. Maintenance and Inspection of Respirators

a. Cleaning and Disinfecting

(1) Each employee shall be provided with a respirator that is clean, sanitary and in good working order.

(2) Respirators shall be cleaned and disinfected using the Respiratory Cleaning Procedures contained in [Appendix B-2 to 29 CFR 1910.134](#) (reference 21) or procedures recommended by the manufacturer if they are equally effective.

(3) The frequency for cleaning and disinfecting is as follows:

(a) Respirators used by only one employee shall be cleaned and disinfected as often as necessary to be maintained in a sanitary condition.

(b) Shared respirators must be cleaned and disinfected prior to use. (Note: The practice of sharing respirators should be minimized.)

(c) Emergency use respirators must be cleaned and disinfected after each use.

(d) Respirators used in fit tests and training exercises must be cleaned and disinfected after use.

b. Storage

(1) Respirators shall be stored so as to protect them from damage, contamination, dust, sunlight, extreme temperatures, excessive moisture and damaging chemicals.

(2) Respirators shall be stored in such a manner as to prevent deformation of the facepiece and valves.

(3) Emergency use respirators shall be kept accessible to the work area, in compartments or covers that are clearly marked as containing emergency respirators, and stored in accordance with the manufacturer's instructions.

c. Inspection

(1) Respirators used in routine situations shall be inspected before each use and during cleaning.

(2) Emergency use respirators shall be inspected at least monthly, and in accordance with the manufacturer's instructions. Note: (Emergency use respirators shall also be checked for proper function before and after each use.)

(3) Escape-only respirators shall be inspected before being brought into the work area.

(4) A respirator inspection includes the following:

(a) Check respirator function, tightness of connections, and the condition of the various parts, including the facepiece, head straps, valves, connecting tubes, cartridges, canisters and filters.

(b) Check the elastic parts for pliability and deterioration.

d. Repairs. Respirators that fail inspections or are otherwise found to be defective shall be removed from service and discarded, repaired, or adjusted by appropriately trained persons, with NIOSH approved parts, according to manufacturer's specifications. Valves, regulators and alarms shall be adjusted or repaired only by the manufacturer or manufacturer's technicians.

e. Identification of Filters, Cartridges and Canisters. Filters, cartridges and canisters must be labeled and color-coded with the appropriate NIOSH approval label. All approved particulate respirators will have a certification label bearing the NIOSH emblems and the certification number ("TC" number). The label is not to be removed and must remain legible.

7. Fit Testing and Face Seal Protection. Employees must be fit tested prior to their wearing a respirator. Employees must be re-tested annually, whenever changes in an employee's physical condition could affect respirator fit, or whenever requested by the employee because the fit is unacceptable. Fit testing must be performed with the same make, model, style and size of respirator that will be used. A sufficient number of respirator models and sizes shall be available so that the respirator is acceptable to and correctly fits the user. [interpretation](#)

a. Fit Test Procedures

(1) Fit tests are either qualitative or quantitative, depending on the respirator type and use, and must follow the detailed fit testing procedures contained in [Appendix A to 29 CFR 1910.134](#) (reference 21).

(2) Qualified fit test technicians shall perform the fit test. To be qualified, a fit test technician must have been trained in both qualitative and quantitative fit test procedures in an approved training course.

b. Records. Records of fit tests must be maintained by the SOHO or supervisor and should include names, dates, types of tests, results and make, model, style and size of the respirator fitted.

c. Face Seal Protection

(1) Prohibitions. Tight fitting face pieces are not to be worn by employees:

(a) who have facial hair that comes between the sealing surface and the face, or that interferes with valve function;

(b) who have any condition that interferes with the seal, such as missing dentures, jewelry, or headgear; or

(c) if corrective glasses, goggles or other PPE interfere with the seal.

(2) User Seal Checks. Employees must perform a user seal check each time they put on the respirator according to the User Seal Check Procedures in [Appendix B-1 to 29 CFR 1910.134](#) (reference 21).

(3) Continued Respirator Effectiveness. The supervisor and SOHO shall maintain appropriate surveillance of the work area and employee exposure. Respirator effectiveness must be re-evaluated when there is a change in work area conditions or degree of employee exposure or stress.

8. Training

a. Required Users of Respirators

(1) All employees who are required to wear respirators will receive initial training in their use and maintenance.

(2) Employees must be trained sufficiently to demonstrate:

(a) a knowledge of why the respirator is required.

(b) how improper fit, usage or maintenance can compromise the protectiveness of the respirator.

(c) the limitations and capabilities of the respirator.

(d) how to deal with emergencies or malfunctions.

(e) how to inspect, don and remove, and check the seal of the respirator.

(f) maintenance and storage procedures.

(g) medical symptoms and signs that may limit or prevent the effective use of respirators.

(h) general requirements of this standard.

(3) Qualified persons who are familiar with the regulatory requirements of the Respiratory Protection Standard and trained in respirator use and fit test procedures shall provide training.

b. Voluntary Users of Respirators. The PLFA will provide all employees voluntarily wearing respirators a copy of the information contained in [Appendix D to 29 CFR 1910.134, "Information for Employees Using Respirators When Not Required Under the Standard."](#)

c. Frequency of Re-Training. Re-training will be provided annually and whenever the following occur:

(1) changes in the workplace or type of respirator used.

(2) inadequacies in the employee's knowledge or use of the respirator are apparent.

(3) any other situation in which re-training is necessary to ensure safe respirator use.

9. Program Evaluation

a. The program administrator shall conduct evaluations of the workplace as necessary to ensure the provisions of the written program are being effectively implemented.

b. The program evaluation shall include consulting with employees required to wear respirators to assess the employee's views on program effectiveness and to identify any problems. Any problems identified shall be corrected.

c. Factors to be assessed include respirator fit, appropriate respirator selection, proper use and maintenance.

10. Recordkeeping

a. Training and fit testing records shall be kept for a minimum of five years. [interpretation](#)

b. Records of medical evaluations shall be kept for the duration of the wearer's employment and 30 years following employment ([DoDI 6055.5](#), reference 7; [29 CFR 1910.1020](#), reference 21).

Industrial Hygiene Program

1. PURPOSE. The purpose of an IH Program is to promote a healthy working environment by anticipating, identifying, evaluating, and controlling health hazards.
2. WORK PLAN. The PLFA SOHO may annually develop a written IH work plan for ensuring workplaces have been evaluated for health hazards. If the PLFA SOHO develops a plan, the plan shall include as a minimum: interpretation
 - a. Organizations Served. Identify the organizations to be served by the IH program, and the authority and responsibility for providing IH services.
 - b. Standards. Identify regulations, standards, policies, and procedures which affect the IH program. Review the impact of new standards which may require reassessments of existing work conditions.
 - c. Priorities. Identify and prioritize the frequency and extent of surveys needed for each workplace based on the expected health risks in each workplace, potential for changes in operations or exposures, and the IH resources available.
 - d. Survey Schedule. Establish an IH survey schedule in coordination with senior management officials of the organizations being served.
 - e. Assigning Resources. Assign IH and other such functional and consultative services which will be used to perform IH surveys when a hygienist is not on staff.
3. WORKPLACE SURVEYS. The PLFA SOHO will ensure the following:
 - a. Periodic IH surveys are performed as outlined in the IH survey schedule to identify health risks and recommend corrective action to commanders and supervisors.
 - b. One-time surveys are performed to respond to supervisor or worker requests, or to review changes to current work practices.
 - c. Workers' compensation claims and other suspected occupational illnesses are investigated to determine work-relatedness and to identify actions to prevent additional exposures. interpretation
 - d. Assist supervisors in reviewing workplace conditions to develop workplace accommodations (work restrictions for pregnant workers, light/restricted duty for injured workers, etc.).
4. RECORD KEEPING. Employee exposure records will be maintained for 40 years, or for 30 years beyond last employment date, whichever is longer (DoDI 6055.5, reference 7; 29 CFR 1910.1020, reference 21). Confidentiality of employee data will be maintained in accordance with DoD Directive 5400.11, "Department of Defense Privacy Program," (reference 28), and DoD Instruction 6055.5, "DoD Industrial Hygiene and Occupational Health" (reference 7). IH survey records will include sufficient information to verify the presence or absence, nature, and degree of exposure to health hazards. These records will typically contain, but are not limited to:
 - a. WORKPLACE DEMOGRAPHICS. A description of the work site surveyed (command, organization, division, building number, room number, area, floor plans, etc.)
 - b. OPERATION. Description of the operations or processes within the area.
 - c. PERSONNEL. Names, gender, civilian or military job series, and social security numbers (SSN) of personnel who are potentially exposed to recognized hazardous materials, conditions, or environments. SSNs are required since this data is an integral part of an employee's medical record.

d. EXPOSURE. An assessment of hazard sources and worker exposures to chemical, biological, and/or physical stress.

e. CONTROLS. Type of control measures in use (e.g. personal protective equipment, ventilation systems, screens/barriers, inter-locks, etc.), the adequacy of these controls, and additional controls recommended.

5. REPORTING

a. SURVEY REPORT. IH will provide survey reports to the SOHO for the workplace surveyed. IH will also enter inspection findings and hazards identified during surveys into SHIRS. [interpretation](#) Where IH does not have access to SHIRS, they will provide this information to the SOHO for entering into SHIRS. The survey report will include:

- (1) a description of operations and hazards evaluated,
- (2) health risks to employees,
- (3) recommendations for controlling health risks,
- (4) written notification to each employee through their supervisor when employees are exposed to health hazards above the action level, and
- (5) written certification of the adequacy of PPE to each employee through their supervisor when employees are required to wear PPE.

b. MEDICAL SURVEILLANCE. IH will provide worker exposure data to the supporting Occupational Medicine office to recommend exposure-based medical surveillance using standard information management systems where available.

6. EQUIPMENT CALIBRATION. IH shall maintain up to date calibration of IH exposure measurement equipment, and records to document this calibration.

7. PLANS REVIEW. IH will review planned changes to facilities and operations to ensure health hazard controls are designed into all new operations. IH shall review and recommend changes to plans, drawings, or technical publications for construction, equipment, or workplace and process modifications. Such reviews will be brought to the attention of the SOHO for appropriate action with the responsible parties. [interpretation](#)

Occupational Medicine Services

1. PURPOSE. PLFAs or installations will ensure that occupational medicine services are available or provided for employees at risk of health effects due to workplace exposures, or for employees being placed in positions requiring medical fitness determinations.

2. SCOPE. The SOHO will assist commanders and directors in arranging for occupational medicine services to be provided by DLA health staff, contract health staff (to include the US Public Health Service, Federal Occupational Health Program), or by ISA or MOU with host military health staff.

interpretation Overseas organizations will follow contract or Host Nation rules regarding Local National Employees. Employee wellness programs and services not related to workplace exposures are not part of occupational medicine services and are not covered in this program.

3. Confidentiality of medical data will be maintained at all times IAW DoD Directive 5400.11, "Department of Defense Privacy Program," (reference 28), and DoD Instruction 6055.5, "DoD Industrial Hygiene and Occupational Health" (reference 7). An EMFS (Employee Medical File System) Manager will be appointed IAW DoDI 6055.5. The EMFS Manager may authorize medical data access to other members of the Occupational Health Program staff as necessary to perform their duties.

4. Examinations

a. Medical Surveillance for Workplace Exposures. Medical examinations will be provided where industrial hygiene evaluations have found the potential for work-related adverse health effects, or where required by OSHA standard (DoDI 6055.5, reference 7). The protocol for each medical examination will be based on DoD 6055.5-M, Occupational Medical Surveillance Manual (reference 8), in consultation with the health staff providing the examination. At no time will SOHOs make medical determinations concerning the actual exam protocols to be utilized nor evaluate the results medically.

(1) Baseline examinations will be performed to provide baseline measurement for comparison to periodic measurements in the detection of early or sub-clinical health effects.

(2) Periodic occupational medical examinations will be offered to detect early or sub-clinical health effects. Abnormal findings will be used to evaluate and treat the individual employee, and will be provided to industrial hygiene for workplace evaluations to prevent further workplace exposures to this or other employees.

(3) Termination of exposure examinations will be offered when the employee's exposure to a specific hazard has ceased due to employee reassignment, changes in existing work processes, or termination of employment. DoD 6055.5-M (reference 8) identifies required termination of exposure examinations.

(4) Termination of employment examinations are required by OSHA standards for more chronic exposures to document employees health condition upon leaving the current employer (e.g., 29 CFR 1910.1001, Asbestos [reference 18]). These examinations will be offered at termination of employment to all employees who have previously been offered periodic examinations. When the most recent periodic examination is less than one year old (at the effective termination date), it may serve as the termination examination.

b. Fitness and Risk Determination. Fitness medical examinations are provided to ensure an employee is capable, from a medical standpoint, of performing specific tasks with or without reasonable accommodation, without

placing the individual or someone else at risk of significant harm. The content of pre-placement and periodic examinations will be determined for each position by the workplace supervisor and the Human Resources office, with the assistance of the occupational medicine staff. Supervisors and Human Resources will review the results of the fitness and risk determination prior to placing an employee in a position with medical requirements.

c. Certified Temporary Medical Condition. Employees should notify the occupational medicine staff about their certified temporary medical condition (e.g., pregnancy, broken arm, etc.) as early as possible so an initial assessment of their work environment and assignment can be made. Where necessary and justified, specific job limitations should be recommended after coordination with the employee's private physician.

d. Administrative examinations or evaluations will be offered as necessary and in accordance with appropriate regulations. Such examinations will be requested and justified in writing by management officials through Human Resources channels. Human Resources officials and the SOHO will ensure that such examinations are not used abusively.

e. Employee Participation. Employees may decline to participate in any medical examination offered; however, their nonparticipation may result in reassignment or personnel action if they are otherwise unable to demonstrate that they are medically fit for the hazards, exposures, and duties of their position. The SOHO may require declining employees to sign a statement that a medical examination was offered but the employee declined.

5. Medical Treatment

a. Emergency medical treatment. Supervisors will ensure that immediate first aid and medical care are provided to an injured employee.

(1) At locations with medical treatment capability, emergency treatment will be provided for all DLA employees, contractors, and visitors in accordance with locally-developed procedures.

(2) At locations without medical treatment capabilities, emergency treatment will be provided by outside sources (e.g., contract, local emergency medical services).

(3) At contractor-operated facilities, first time emergency medical treatment of injuries may be provided by the contractor.

(4) CPR and first aid training.

(a) For those workplaces within four minutes of an infirmary, clinic or hospital, it is up to the installation commander to decide if he/she wants to provide CPR and first aid training and response for employees. Those workplaces that are more than 4 minutes from an infirmary, clinic or hospital must provide employees trained in CPR and first aid. For those workplaces, 1 in 25 must be trained in first aid and a sufficient number must be trained in CPR. The determination of sufficiency is up to the commander.

(b) Emergency ambulance service personnel will receive CPR and first-aid training appropriate for assigned duties.

(c) High voltage electricians will be trained in CPR.

b. Non-emergency medical treatment. DLA will offer medical diagnosis and treatment to employees for occupationally related health conditions.

Employees will be advised that they have the option of selecting health care provided by DLA or their own private provider.

c. Medical Treatment Evaluations.

(1) Supervisors may encourage, but not require, employees to report injury/illness to the DLA-provided medical services before seeking medical care from their own health care provider.

(2) Employees who become injured or ill because of an occupational incident or exposure are expected to report to the DLA-provided medical service facility, as soon as possible, for evaluation and documentation in the employee's medical folder of the event. The necessary treatment is offered appropriate to the problem but the worker has the option of receiving treatment at the facility of his or her choice.

(3) Employees returning to a duty status from work related injury/illness should clear through the DLA-provided medical service facility with documentation from their health care provider. This will help ensure it is safe for the employee to return to a specific work setting in order to avoid premature return to work and risk of aggravation of the injury/illness or re-injury to the employee.

d. Treatment of non-occupational medical conditions. The occupational medicine physician or staff will refer employees to their private health care provider for definitive diagnosis and treatment of non-occupational medical conditions. The staff may provide, to the extent possible, any treatments requested in writing by the employee's private physician. Such written authorization must be renewed every 3 months. The occupational medicine physician must approve any exceptions to the above.

e. Flu immunizations may be offered to employees.

f. Travel immunizations. DLA employees will receive appropriate immunizations at DLA expense prior to official travel outside the United States. The Centers for Disease Control are the federal authority for recommending immunizations for each country visited ([DoD Instruction 6205.2, "Immunization Requirements" \[reference 29\]](#)). Current immunization recommendations are posted to the CDC web site at "<http://www.cdc.gov>".

Ergonomics

1. Purpose. A comprehensive and effective written Ergonomics Program shall be established and maintained at each DLA Activity. As a minimum, an Ergonomics Program will comply with [DoD Instruction 6055.1, enclosure 6](#). This enclosure provides additional guidance for establishing the Primary Field Level Activity's (PLFA's) ergonomics program component as an integral part of the safety and occupational health program. For the ergonomics program to be successful, all members of the working community must be considered equal and share a commitment to using ergonomics to eliminate workplace injury and illnesses. An effective ergonomics program can:

- a. prevent workplace injuries,
- b. reduce medical and associated costs of work-related musculoskeletal disorders (WMSDs), and
- c. improve productivity through enhanced employee morale and physical well being.

2. Responsibilities. In addition to the general responsibilities for implementing the SOH Program, the following responsibilities are assigned to implement the ergonomics program.

- a. PLFA Commanders
 - (1) Demonstrate commitment to the ergonomics program.
 - (2) Establish an ergonomics committee as part of the SOH council ([paragraph E.3.](#)). A recognized employee representative will be invited to be a member of the PLFA ergonomics committee.
 - (3) Integrate ergonomics into the SOH program.
 - (4) Approve the PLFA's ergonomics plan based on the recommendations of the SOH Council, after consultation and negotiation with appropriate employee representatives.
 - (5) Provide sufficient funds and other resources to carry out all responsibilities related to this program.
 - (6) Work with installation personnel, employee representatives, and appropriate regulatory authorities to effectively address ergonomics issues.
 - (7) Require that appropriate reporting and record keeping procedures be followed.
- b. The SOHO:
 - (1) Designates a PLFA ergonomics officer (EO) and recommends membership of the ergonomics committee based on recommendations from the EO and other qualified professionals. The SOHO should consider for members:
 - (a) Chairperson. The PLFA EO:
 - [1] Serves as chairperson of the ergonomics committee.
 - [2] Is a health or safety professional that must receive at least 40 hours of formal training in ergonomics (i.e., occupational medicine physician, industrial hygienist, occupational health nurse, other health care professional, or SOHO who has received at least 40 hours of formal ergonomics training).
 - (b) Core Membership. The ergonomics committee will include, but need not be limited to:
 - [1] Industrial hygienist
 - [2] Safety professional
 - [3] Health Care Activity representative(s) where available (for example, physician, nurses, occupational and physical therapists, physician assistant, and other trained medical personnel).
 - [4] Employee Representative(s)

- [5] Human Resources Customer Support Unit Representative
- [6] Injury Compensation Program Administrator
- (c) Suggested support and advisory membership
 - [1] Director of Contracting Support (or equivalent)
 - [2] Director of installation maintenance
 - [3] Logistics Chief
 - [4] Other offices responsible for equipment purchasing decisions (e.g. computer work stations)
 - [5] Engineers and maintenance personnel
 - [6] SLFA SOHOs, where available.
- (2) Obtains and forwards the following records to the PLFA EO:
 - (a) Injury and illness reports, Log of Federal Occupational Injuries and Illnesses, or equivalent.
 - (b) Federal Employee Compensation Act (FECA) claims.
 - (c) Sanitized mishap reports.
 - (d) Sanitized medical and safety records (as appropriate, after coordinating procedures with the EMFS Manager for handling confidential medical information). interpretation
 - (e) Work force reports (including civilian pay reports of lost duty time as a result of injury or illness).
- (3) Provides reports to the PLFA's command group.
- (4) Advises the commander on ergonomic issues.
- c. Medical Staff:
 - (1) Provide medical components of the ergonomics program.
 - (2) Perform or assist in performing in-depth ergonomic assessments as needed.
 - (3) Advises the SOHO on appropriate individuals for membership on the ergonomics committee.
 - (4) Ensures a written protocol is developed for the early recognition, evaluation, treatment, and follow-up of WMSDs among personnel.
 - (5) At installations where the Installation Medical Authority (IMA) is directed by their command to comply with the host regulations, provision of medical services will be coordinated by the PLFA EO.
 - (6) Keep accurate records of identified WMSDs and high-risk work areas and solutions. Provide these records to the ergonomics committee for review and tracking. The tracking records will be stored in SHIRS. Note: Diagnosis of disease from reported symptoms is performed only by a health care provider. The work relatedness of disease is determined by the U.S. Department of Labor.
- d. The PLFA EO:
 - (1) Is an industrial hygienist, occupational health nurse or other qualified safety or health professional who has received at least 40 hours of formal ergonomics training.
 - (2) Advises the SOH Official/Manager on appropriate individuals for management membership on the ergonomics committee.
 - (3) Chairs the ergonomics committee, providing an interface between the ergonomics committee and the SOH Council.
 - (4) Develops and implements the PLFA's ergonomics plan, with the assistance of the ergonomics committee and approval of the SOH council.
 - (5) Manages or performs the worksite analysis, and ensures its completion.
 - (6) Ensures accurate record keeping for the ergonomics committee.
- e. The ergonomics committee:
 - (1) Under the SOH Council, assists in developing and implementing the PLFA's ergonomics plan.
 - (2) Plans, oversees and participates in:
 - (a) Gathering and evaluating injury, lost work time, trend, productivity and complaint data on work sites and work processes.
 - (b) Identifying existing and potential WMSDs.
 - (c) Conducting worksite evaluations.
 - (d) Setting priorities for abatement of identified WMSDs.
 - (e) Implementing corrective actions.

(f) Providing appropriate worker training.

(3) Develops methods to evaluate the effectiveness of the corrective actions and documents the results.

(4) Works with medical personnel in the identification of potential WMSDs and advises medical personnel on ergonomic changes related to the workstation, tasks, and tools.

(5) Provides semiannual reports to the SOH Council and local union presidents of the PLFA.

f. Trained ergonomics personnel who have met the minimum standards as specified in the definitions for this Instruction:

(1) Serve on the PLFA ergonomics committee.

(2) Assist with the identification and control of WMSDs (alone or as members of the ergonomics committee).

(3) Perform in-depth ergonomic assessments of identified problematic work areas, tasks, and tools to determine WMSD risk factors.

(4) Document all evaluations, recommendations, and actions related to ergonomics and the effectiveness of the actions.

(5) Provide ergonomics training and education for personnel. Persons tasked to provide training should obtain refresher ergonomics training to maintain expertise.

(6) Work with medical personnel as a team member to identify potential WMSDs and inform medical personnel of ergonomic changes related to workstations, tasks, and tools.

(7) Participate in the ergonomics committee's semiannual ergonomics program evaluation and review.

(8) Keep accurate records of identified WMSDs and high-risk work areas and solutions. Provide these records to the ergonomics committee for review and tracking. Store the tracking records in SHIRS.

g. Industrial hygiene (IH) personnel:

(1) Serve on the ergonomics committee.

(2) Consider WMSDs during routine worksite evaluations.

(3) Perform or assist in performing in-depth ergonomic assessments as needed.

(4) Assist in solving problems related to identified WMSDs.

(5) Keep accurate records of identified WMSDs and high-risk work areas and solutions. Provide these records to the ergonomics committee for review and tracking. Track the assessments in SHIRS.

(6) Provide ergonomics training and education to personnel. Trainers should obtain refresher ergonomics every three years or as specified by OSHA, DoD, or DLA standards.

(7) Work with medical personnel in the identification of potential WMSDs and inform medical personnel on ergonomic changes related to the workstation, job tasks, and tools.

h. PLFA safety personnel trained in ergonomics:

(1) Should serve on the PLFA's ergonomics committee.

(2) Oversee the safety aspects of the ergonomics program.

(3) Coordinate the annual SOH worksite visits with the other key ergonomics program personnel, and consider or evaluate WMSDs during the safety inspection or survey.

(4) Maintain appropriate injury and illness records, such as accident reports and the log of Federal occupational Injuries and Illnesses.

(5) Review injury and illness records in SHIRS related to WMSDs, develop trend analyses, and report results to the ergonomics committee.

(6) Provide or assist with ergonomics training and education. Trainers should obtain refresher ergonomics every three years or as specified by OSHA, DoD, or DLA standards.

(7) Perform or assist in performing in-depth ergonomic assessments as needed.

(8) Assist in solving problems related to identified WMSDs.

(9) Keep accurate records of identified WMSDs and high-risk work areas and solutions. Provide this information to the ergonomics committee for

review and tracking. Record identified potential WMSDs and corrective actions in the SHIRS.

(10) Work with medical personnel in the identification of potential WMSDs and inform medical personnel on ergonomic changes related to the workstations (processes, tasks, tools etc.). NOTE: Diagnoses of reported WMSDs is only done by a health care provider. The work relatedness of a disease is determined by the US Department of Labor.

i. Medical and occupational health care personnel trained in ergonomics.

(1) A representative from specific health care areas (for example, physician, nurse, occupational and physical therapists) should serve on the PLFA's ergonomics committee.

(2) Develop and conduct baseline medical screening for new personnel whose positions have specific medical standards, physical requirements, or are covered by a medical evaluation program established under applicable regulations ([5 CFR 339.301](#), reference 30).

(3) Develop a written protocol for the early recognition, evaluation, treatment, and follow-up of WMSDs among personnel.

(4) Assist trained ergonomics personnel to identify modified or restricted-duty jobs.

(5) Make specific recommendations to the Human Resources Customer Support Unit on the assignment of injured workers to modified or restricted-duty jobs.

(6) Assist in ergonomics training and education.

(7) Conduct ergonomic job evaluations when required.

j. The Human Resources Customer Support Unit staff:

(1) When assisting in the placement of employees with WMSDs, will take into account the recommendations and concerns of local health care personnel, and the ergonomics committee.

(2) Ensures newly appointed supervisors, managers, and personnel receive appropriate ergonomics training within one year so that they are made aware of the benefits and their responsibilities.

(3) Maintains the statistical data on lost duty time as a result of injury or illness and provides this information for review by the ergonomics committee.

(4) Appoints at least one representative to serve on the ergonomics committee. This person should be the Injury Compensation Program Administrator (i.e., FECA collateral duty personnel).

k. The Chief of Equipment Contracting, or equivalent:

(1) Appoints an advisory or support representative to serve on the ergonomics committee.

(2) Implements the recommendations of the ergonomics personnel to reduce WMSD risk factors when feasible.

(3) Ensures the integration of ergonomic considerations into the purchase of new equipment and furniture.

l. The Chief of Facilities Management or equivalent:

(1) Integrates ergonomic considerations into facility modifications and construction.

(2) Implements recommendations from trained ergonomics personnel to reduce WMSD risk factors when feasible.

(3) Appoints an advisory or support representative to serve on the ergonomics committee.

(4) Ensures engineers and maintenance personnel:

(a) Prevent and correct WMSDs through job and workstation design and proper maintenance.

(b) Apply ergonomics concepts to conditions at the facility.

m. The Chief of Logistics Operations, Installation Engineering Support or equivalent:

(1) Ensures the integration of ergonomic considerations into the purchase of new operations equipment.

(2) Implements recommendations from trained ergonomics personnel to reduce WMSD risk factors when feasible.

(3) Consults with trained ergonomics personnel to assist in the evaluation of equipment and furniture for ergonomic design.

(4) Appoints an advisory or support representative to serve on the ergonomics committee.

n. Recognized employee representatives:

(1) Serve as members of the ergonomics committee.

(2) Encourage personnel to recognize and report WMSDs.

o. The Supervisor:

(1) Supervises work practices of employees:

(a) Ensuring that personnel are trained to recognize and report hazardous work conditions.

(b) Recognizing early symptoms of potential WMSDs and report concerns through the appropriate channels.

(2) Routinely reviews work areas, tasks, and equipment for potential WMSD risk factors.

(3) Supports the ergonomics program by coordinating with trained ergonomics personnel to reduce risks to the workers.

(4) Maintains effective schedules for facility, equipment, and tool maintenance, adjustments, and modifications.

(5) Holds personnel accountable for following safe work practices and recognizes employee initiatives to improve operations, conditions and procedures through official recognition and incentives where appropriate.

(6) Reports to the Safety Office all employee reports of symptoms of WMSDs or WMSD risk factors in the workplace.

(7) Assists employees in completion of workers' compensation claim forms in connection with a suspected WMSD. Note: the supervisor cannot require an employee to file or not to file a claim.

p. Employees:

(1) Modify work practices as recommended to minimize WMSDs.

(2) Notify supervisors of WMSD risk factors in the workplace.

(3) Recognize and report symptoms of WMSDs early.

(4) Perform recommended conditioning activities.

(5) Actively participate in the suggestion process

(6) Routinely review work areas, tasks, and tools for potential WMSD risk factors.

3. Technical support. Technical assistance may be requested through command channels to the HQ DLA SOHO.

4. Ergonomics Program Goals. The goals of the ergonomics program are to:

a. Prevent injuries and illness by eliminating or reducing worker exposure to WMSD risk factors.

b. Reduce the potential for fatigue, error, and unsafe actions by adapting the job and workplace to be within worker's capabilities and physical limits.

c. Increase the overall productivity of the workforce.

d. Reduce workforce compensation claims and associated costs.

e. Identify early and prevent WMSDs to preserve and protect DLA's workforce while decreasing related costs.

5. Organizational involvement. A cooperative partnership among all levels of the working community is essential in achieving the goals of the ergonomics program. Command emphasis, management commitment, and demonstrated involvement provide the motivation needed and organizational resources to implement a sound ergonomics policy. All levels of personnel (manager, supervisor, and worker) are responsible for injury prevention through the identification and resolving WMSDs.

6. Effects of work-related musculoskeletal disorders

a. Health effects. Repeated biomechanical stress and microtrauma cause or aggravate WMSDs. Over time, repeated microtrauma can evolve into a painful, debilitating condition involving muscles, tendons, tendon sheaths, and nerves. Examples of WMSDs are:

- (1) Tendinitis.
- (2) Tenosynovitis.
- (3) Bursitis.
- (4) Chronic muscle strain.
- (5) Nerve entrapment syndromes (carpal tunnel syndrome).

b. Economic effects. The expense associated with a poorly designed workplace is considerable and includes both direct and indirect costs.

- (1) Direct costs include medical treatment, rehabilitation, and workers' compensation costs.
- (2) Indirect costs include lost work time, decreased productivity, decreased work quality, retraining costs, and diminished morale.

7. Occupational risk factors

a. Research identifies the following as specific workplace conditions that can contribute to the development of WMSDs.

- (1) Repetitive motions (especially during prolonged activities).
- (2) Sustained or awkward postures.
- (3) Excessive bending or twisting of the wrist.
- (4) Continued elbow or shoulder elevation (for example, overhead work).
- (5) Forceful exertions (especially in an awkward posture).
- (6) Excessive use of small muscle groups (for example, pinch grip).
- (7) Acceleration and velocity of dynamic motions.
- (8) Vibration.
- (9) Mechanical compression.
- (10) Restrictive workstations (for example, inadequate clearances).
- (11) Improper seating or support.
- (12) Inappropriate hand tools.
- (13) Machine-pacing and production-based incentives.
- (14) Extreme temperatures.
- (15) Extended exposure to hazardous or annoying noise.

b. The combined effect of several risk factors in one job or workstation may lead to a higher probability of causing a WMSD.

8. Ergonomics Program Plan. The PLFA ergonomics plan focuses on the identification and control of improper workplace and work process design to protect personnel from injury and illness due to exposure to occupational risk factors.

a. Practical effects. Implementing a PLFA ergonomics plan will help reduce the number of WMSDs and related medical compensation claims, resulting in improved product quality, productivity, and personnel morale as well as decreased costs.

b. Plan development and approval

(1) The PLFA EO and the ergonomics committee develop, document and maintain the PLFA ergonomics plan. They may:

(a) Solicit input to the plan from health care providers, including physicians, nurses, occupational therapists, physical therapists, and physician assistants.

(b) Coordinate the plan with the installation or activity Health Promotion Coordinating Committee and wellness program coordinator as appropriate.

(2) The installation SOH Council recommends the ergonomics plan to the commander for approval and communicates the plan to all managers, supervisors, and workplace personnel.

c. Plan Outline

(1) The PLFA ergonomics plan should reflect the needs and requirements of the individual activities of the PLFA. The PLFA EO and the committee may use the structure and content provided in this document in developing an PLFA ergonomics plan that addresses each of the items.

- (a) Program goals and objectives.
- (b) Program interface with existing programs.
- (c) Specific critical program elements for ergonomic

intervention:

- [1] Worksite analysis.
- [2] Hazard prevention and control.
- [3] Health care management.
- [4] Education and training.
- [5] Ergonomics program evaluation.

(2) The extent of involvement in each of the five critical program elements will vary according to the hazards and concerns at each activity; however, some degree of activity in each of the five critical program elements is required for an effective program.

9. Worksite Analysis

a. Problem identification. Use the following passive and active surveillance to identify jobs or worksites with WMSD risk factors.

(1) Systematic passive surveillance. This procedure involves the analysis of data provided in existing monthly or quarterly reports. This analysis can identify WMSD problems, set intervention priorities, and organize the ergonomics effort. The office responsible for maintaining logs, or reports will perform the systematic passive surveillance and communicate upon request the results to the EO and the ergonomics committee. Sources of data include:

- (a) Routine injury and illness reports, including DLA Form 1591 Mishap Reports.
- (b) Log of federal occupational injuries and illnesses or equivalent.
- (c) FECA claims from HROC and from SHIRS.
- (d) Medical and safety records.
- (e) Workforce reports (including civilian and active-duty personnel and pay reports of lost duty time as a result of injury or illness) and suggestions.

(2) Systematic active surveillance. This procedure involves focused and active efforts to gather information about WMSD hazards at worksites and to identify workers at risk of developing a cumulative trauma disorder (CTD). Trained ergonomics personnel will perform active surveillance in conjunction with IH or safety surveys or regular training.

(a) Examples of active surveillance procedures include:

[1] Questionnaires and surveys. Supervisor and worker questionnaires and symptom or body part discomfort surveys provide information about WMSD hazards, often before actual injuries occur. Employee questionnaires and surveys will be coordinated with the local employee representative prior to use. Trained ergonomics personnel can administer these surveys during walk-through surveys or as part of regular training.

[2] Observation. Direct observation by trained ergonomics personnel conducting regular walk-through IH or safety surveys can identify WMSD hazards. Worker interviews during these surveys can identify tasks or situations that are uncomfortable and may indicate WMSD risk factors. For example, workers note that cold temperatures make it difficult to grip hand tools.

[3] Sentinel event or incident reporting. Specific acute health or performance events, such as wrist pain, back pain, or increased errors, may be indicative of WMSD risk factors. Use a specific reporting procedure to facilitate reports.

[4] Case referrals. Use case referrals to identify a work area with potential WMSD risk factors. For example, a laboratory technician seeks medical care for hand and wrist pain and provides an occupational history that indicates possible worksite risk factors.

(b) The presence of one WMSD via symptoms, FECA claims etc., should trigger an active surveillance survey using appropriate questionnaires or surveys. Trained ergonomics personnel will perform systematic active surveillance at all worksites or re-evaluate the worksite at least once per year. Also, trained ergonomics personnel will perform walk-through surveys for any new or significantly changed job, process, equipment, or method.

(c) In many cases, corrections to the WMSD hazards or risk factors are simple, quick, on-the-spot workplace changes. Trained ergonomics personnel conducting regular walk-through surveys can identify and implement the solution immediately. More complex problems will require prioritization and detailed analysis.

(d) If a worksite or job is identified as high risk, special medical surveillance may be indicated.

b. Prioritizing surveillance. The ergonomics committee or the appropriate committee member (for example, IH, safety, occupational health nurse, etc.) will prioritize activities and worksites for detailed analysis based on the passive and active surveillance information. The prioritization may be based on incidence rates, the number of workers affected, direct costs, lost work time, or severity of cases. Calculate incidence rates by unit, work section, or job series to identify high-risk areas. Use FECA claims information to identify high cost injuries and high-risk work areas. Ergonomic injuries can be identified by a query in SHIRS for "event or exposure codes" between '22' and '2399'. ([US Department of Labor, Bureau of Labor Statistics, "Occupational Injury & Illness Classification Manual," reference 31](#)).

c. Detailed analysis

(1) When requested by management, the ergonomics committee or the appropriate committee member shall provide an analysis of continuing job requirements for lifting.

(2) To further evaluate those jobs or worksites having WMSD risk factors as determined by systematic passive and active surveillance, complete a more detailed analysis. When conducting the detailed analysis, trained ergonomics personnel should systematically:

(a) Consider the concept of multiple causation (see definition) and the degree of WMSD risk.

(b) Look for trends, including age, gender, work task, and time of injury.

(c) Identify the work tasks or portions of the process that contain risk factors.

(d) Identify both problems and solutions.

(3) The following data, analysis tools, and methods may be helpful during a detailed analysis:

(a) Incidence rates (log of federal occupational injuries and illnesses or equivalent), accident and injury reports, and lost work time or absenteeism reports by job, unit, department, or installation.

(b) Checklists, questionnaires, and interview.

(c) Direct observation, videotape analysis, and job analysis.

(d) Tests, such as:

[1] Revised [National Institute for Occupational Safety and Health \(NIOSH\) equation for the design and evaluation of manual lifting tasks](#) (reference 32).

[2] Static and dynamic strength testing.

[3] Timed activity analysis.

[4] Biomechanical analysis and cardiovascular measurements.

10. Hazard Prevention and Control

a. Intervention hierarchy. The primary method of preventing and controlling exposure to WMSD hazards is through effective design (or redesign) of a job or worksite. The following paragraphs define intervention methods in order of priority.

b. Process elimination. Elimination of the demanding process essentially eradicates the WMSD hazard. For example, eliminate the use of a hand-held bar code scanner for inventory management personnel by providing an automatic bar code scanner.

c. Engineering controls. Ergonomic engineering controls redesign the equipment or worksite to fit the limitations and capabilities of workers. Where an ergonomic evaluation determines that engineering controls or accommodations are required, such controls or accommodations shall be provided at no cost to the employee. Equipment or work-site redesign typically offers a permanent solution. For example, provide a video display terminal workstation that can be adjusted to a wide range of anthropometric dimensions.

d. Substitution. Substituting a new work process or tool (without WMSD hazards) for a work process with identified WMSD hazards can effectively eliminate the hazard. For example, replace hand tools that require awkward wrist positions (extreme wrist flexion, extension, or deviation) with tools that allow a neutral wrist posture.

e. Work practices. Practices that decrease worker exposure to WMSD risk factors include changing work techniques, providing personnel conditioning programs, and regularly monitoring work practices. Also included are maintenance, adjustment, and modification of equipment and tools as needed.

(1) Proper work techniques include methods that encourage:

- (a) Correct posture.
- (b) Use of proper body mechanics.
- (c) Appropriate use and maintenance of hand and power tools.
- (d) Correct use of equipment and workstations.

(2) Personnel conditioning refers to the use of a conditioning or break-in period. New and returning personnel may need gradual integration into a full workload, depending on the job and the person. Supervisors, trained ergonomics personnel, and health care personnel should identify those jobs that require a break-in period. Health care personnel should evaluate those personnel returning from a health-related absence and define the break-in period for each individual person ([5 CFR 339.301](#), reference 30).

(3) Regular monitoring of operations helps to ensure proper work practices and to confirm that the work practices do not contribute to cumulative trauma injury or hazardous risk factors.

(4) Effective schedules for facility, equipment, and tool maintenance, adjustments, and modifications will reduce WMSD hazards. This includes ensuring proper working conditions, having sufficient replacement tools to facilitate maintenance, and ensuring effective housekeeping programs. Tool and equipment maintenance may also include vibration monitoring.

f. Administrative controls. Where engineering controls are not feasible, consider using administrative controls to limit the duration, frequency, and severity of exposure to WMSD hazards. Examples of administrative controls include, but are not limited to:

(1) Instituting job rotation as a preventive measure, with the goal of alleviating physical fatigue and stress to a particular set of muscles and tendons. Do not use job rotation in response to symptoms of cumulative trauma. This can contribute to symptom development in all personnel involved in the rotation schedule rather than preventing problems. Trained ergonomics and health care personnel should conduct an analysis of the jobs used in the rotation schedule.

(2) Reducing the number and speed of repetitions by having worker input regarding production speed (that is, using worker-based rather than machine-based production speed).

(3) Providing rest breaks to relieve fatigued muscle-tendon groups. Determine the length of the rest break by the effort required, total cycle time, and the muscle-tendon group involved.

(4) Increasing the number of personnel assigned to the task (for example, lifting in teams rather than individually).

(5) Providing modified-duty or restricted-duty assignments to allow injured muscle-tendon groups time to rest, assisting in the healing process. Make every effort to provide modified-duty or restricted-duty assignments when physical limitations (as identified by a health care provider) allow the worker to return to work performing less than his or her normal work requirements. In regard to modified- or restricted-duty assignments:

(a) A health care provider should specifically identify assignments or job tasks for the individual worker based on his or her symptoms, capabilities, and limitations.

(b) Health care providers with specific knowledge in both occupational demands and cumulative trauma injuries should cooperate with trained ergonomics personnel to develop a list of jobs with low WMSD risk.

(c) Civilian personnel representatives and supervisors, in conjunction with health care personnel, should identify modified-duty assignments and tasks and write descriptions for these assignments and tasks that conform to documented requirements. A combination of tasks from one or more jobs can be used as a modified duty assignment. The description for each modified duty assignment should consider WMSD risk factors and muscle-tendon groups required to perform the job.

g. Personal protective equipment (PPE). PPE is not necessarily recommended for controlling exposure to WMSD hazards, since little research has been conducted to support claims of its usefulness.

(1) Appliances such as wrist rests, back belts, back braces, etc., are not considered PPE. Before purchasing such devices, discuss their effectiveness with trained ergonomics personnel. DoD does not support the blanket use of back belts as a back injury preventive measure. Anti-vibration gloves are an example of PPE that addresses WMSD hazards.

(2) Consider WMSD hazards when selecting PPE. The PPE:

(a) Should be properly worn or used according to manufacturers' specifications.

(b) Should be available in a variety of sizes.

(c) Should accommodate the physical requirements of personnel and the job.

(d) Should not contribute to WMSD hazards.

11. Health Care Management

a. Written protocol. A written protocol should be developed for the early recognition, evaluation, treatment, and follow-up of WMSDs. The procedural aspects of the protocol will be coordinated with the local employee representative. This chapter provides the structure and much of the content of this protocol. The protocol includes communication with supervisors and personnel to identify worksite problems and implement recommendations.

b. Early evaluation of employees with symptoms. Early recognition and health care management of WMSDs are critical to reduce the impact of injury on both personnel and the DLA activity.

(1) Common symptoms of WMSDs can include (but are not limited to) pain, tingling, numbness, stiffness, and weakness in the neck, shoulders, arms, hands, back, and legs. Other symptoms can include headaches, visual fatigue, and increased errors.

(2) Personnel with symptoms of WMSDs should report to health care personnel for an evaluation.

(a) Active-duty military personnel should report to their primary care provider.

(b) Civilian personnel should report to Occupational Medicine with the appropriate forms.

[1] Department of Labor (DOL) Form CA-2, "Notice of Occupational Disease and Claim for Compensation," for all WMSDs except back injuries.

[2] DOL Form CA-1, "Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation" for back injuries.

[3] DOL Form CA-16, "Authorization for Examination and/of Treatment".

(3) Supervisors should encourage personnel with WMSD symptoms to report for a medical evaluation in a timely manner.

(4) Supervisors may not place disincentives as an impediment to personnel reporting WMSDs.

c. Medical evaluation. The initial medical evaluation of a patient with a possible WMSD should include a detailed medical and occupational history and a physical examination. A standardized questionnaire is a useful tool for obtaining the history. The following information should be obtained from DLA or outside sources as appropriate. Health care personnel, within their approved scope of practice, will:

(1) Complete a medical and occupational history that includes:

(a) Job title or series, and number of years and months at that job.

(b) Prior work history.

(c) A detailed description of current job tasks and the amount of time normally spent on each task.

(d) A detailed description of symptoms to include location, character (such as burning, sharp, dull, pins and needles), severity, onset, duration, and exacerbating and relieving factors.

(e) Lost time or limited duty due to symptoms.

(f) Prior evaluation, diagnosis, and treatment of symptoms.

(g) Other existing medical conditions and history of trauma and surgery.

(h) Activities and hobbies outside of work.

(i) Current medications.

(2) Conduct a physical examination that includes, but is not limited to:

(a) Appearance (swelling, muscle atrophy, erythema, ecchymosis).

(b) Range of motion and muscle strength.

(c) Neurologic assessment (motor, sensory, reflexes).

(d) Vascular assessment (pulses, capillary refill).

(e) Evaluation for pain and tenderness.

(f) Special tests, such as median nerve percussion (Tinel's sign) and the wrist flexion test (Phalen's test) when appropriate.

(3) Perform additional testing as indicated, such as nerve conduction velocities, laboratory tests, and radiographic procedures.

d. Determining occupational illness and injury

(1) To be recorded as an occupational illness or injury, the condition must be diagnosed by a physician, registered nurse, or other person who, by training or experience, is capable of making such a determination (such as an occupational therapist, physical therapist, or physician assistant).

(2) To be classified as an occupational illness or injury, the condition must meet the following criteria:

(a) Either physical findings or subjective symptoms must exist, that is, at least one physical finding (for example, positive Tinell's, Phalen's, or Finkelstein's test; swelling, redness, or deformity; or loss of motion or strength) or at least one subjective symptom (for example, pain, numbness, tingling, aching, stiffness, or burning).

(b) At least one of the following response actions must occur: medical treatment (including self-administered treatment if made available to personnel by their employer), lost or restricted work activity, or transfer or rotation to another job.

(c) Cumulative trauma disorders must be associated with repeated trauma, and exposure at work must have caused or contributed to the onset of symptoms or aggravated existing symptoms.

e. Medical Treatment. Encourage civilian personnel with a suspected WMSD to seek evaluation and treatment in a servicing medical treatment facility

where possible. Health care personnel will usually try conservative therapy before invasive treatment.

f. Modified or restricted duty. Health care personnel will coordinate with trained ergonomics personnel to recommend duty assignments that will not aggravate a patient's condition ([see paragraph 10.f.\(5\)](#)).

g. Medical follow-up. Personnel (healthcare or other trained personnel) will perform regular follow-up for employees being treated for WMSDs to monitor the efficacy of therapy and worksite intervention.

h. Medical surveillance

(1) Work-related musculoskeletal disorders do not require a general screening medical surveillance program. Instead, use the methods of problem identification as described in [paragraph 9.a](#). Health care personnel should cooperate with members of the ergonomics committee:

(a) Where health care personnel are located on site, it is recommended that they participate in the systematic worksite walk-through survey when practical. Participation will add to the effectiveness of the survey, help to maintain proficiency and knowledge about local operations and work practices.

(b) Provide written documentation of the walk-through survey to the as determined by the PLFA EO. Documentation should include date, area(s) visited, risk factors identified, actions taken (if any), and any needed prioritized follow-up.

(2) Special medical surveillance may be indicated for:

(a) Specific jobs where a high incidence of WMSDs has been demonstrated.

(b) Specific jobs that have been identified as high risk based on systematic active surveillance and detailed analysis as discussed in [paragraph 9.a.\(2\)](#) and [9.c..](#)

(c) Employees returning to work after a work related injury or other serious injury/illness.

(3) Where deemed prudent, maintain baseline and periodic health assessment results in Employee Medical File (EMF). Pay attention to any changes that could indicate a WMSD.

i. Reporting. Occupational health, safety, and health care personnel will use the following forms to document WMSDs and perform passive surveillance. These findings will be reported to the ergonomics committee in a descriptive or statistical format that will protect the privacy of the employees.

(1) SHIRS Log of Occupational Injuries and Illnesses or equivalent.

(2) DOL Form CA-2 (all WMSDs, where symptom are reported, except back injuries).

(3) DOL Forms CA-1, CA-16, and CA-17 (Duty Status Report)

(4) Standard Form (SF) 600 (Chronological Record of Medical Care) in the medical record. NOTE: Information obtained regarding an employee's medical condition or history "shall be treated as confidential except that supervisors and managers may be informed regarding necessary restrictions on the work and duties of the employee and necessary accommodations" ([29 CFR 1630.14\(c\), reference 31](#)).

j. Worksite evaluation referrals. Health care personnel who treat a patient with a suspected WMSD will request a workstation evaluation for the patient. Trained ergonomics personnel, together with healthcare personnel, should conduct the workstation evaluation.

12. Education and Training

a. Education requirements

(1) The PLFA EO will have:

(a) A minimum of 40 hours of formal ergonomics training. Formal training is classroom instruction, exercises, supervised workstation assessment, and individual learning assignments.

(b) The technical knowledge to anticipate, recognize and evaluate hazardous conditions, and recommend corrective actions.

(2) Key trained ergonomics personnel (typically health care, occupational health, industrial hygiene, environmental science, safety, or engineering personnel) will have:

(a) A minimum of 40 hours of formal ergonomics training such as the basic 40-hour ergonomics course offered by the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) or equivalent.

(b) The technical knowledge to anticipate, recognize and evaluate hazardous conditions, and recommend corrective actions.

(3) Ergonomics committee members, and other personnel (e.g., managers, supervisors, collateral duty safety monitors) providing assistance in recognizing WMSDs will receive basic ergonomics training, to include elements listed in paragraph [12.b.\(3\)\(b\)](#), from trained ergonomics personnel or as outlined by the SOHO in the PLFA Ergonomics Plan.

(4) For information on available courses, request assistance through HQ DLA DSS-EH. Information and training is also available from USACHPPM.

b. Training requirements. Personnel responsible for administering the installation ergonomics program will receive appropriate special training. Training is necessary for all levels of personnel to understand and recognize potential WMSDs and actively participate in the ergonomics effort.

(1) Personnel requiring training.

(a) All personnel who are exposed to WMSD hazards.

(b) Supervisors.

(c) Managers.

(d) Engineers and maintenance personnel.

(e) SOH personnel.

(f) Collateral duty safety personnel.

(2) Personnel who may conduct training.

(a) Trained ergonomics personnel.

(b) Health care personnel conducting specific portions of training, such as those related to health risks.

(3) Curriculum considerations. Trained ergonomics personnel will:

(a) Present training at a level appropriate to ensure audience comprehension.

(b) Include in the training curriculum an overview of:

[1] The potential risk of WMSDs.

[2] The possible causes and symptoms.

[3] How to recognize symptoms and report WMSDs.

[4] The means of prevention.

[5] The sources of treatment.

(c) Include methods for evaluating the effectiveness of the ergonomics effort, as discussed in [paragraph 13](#).

(4) Types of training

(a) General training. Upon evaluation of the potential WMSD risks, personnel who are potentially exposed to WMSDs hazards will receive formal instruction on hazards associated with their jobs and equipment. Personnel will receive training at their initial job orientation and annually thereafter until the WMSD hazard is eliminated or reduced to an acceptable level. Based on the ergonomic risk assessment the general training will include elements listed in paragraph [12.b.\(3\)\(b\)](#).

(b) Specific training. New and reassigned personnel who are exposed to WMSDs will receive an initial orientation and hands-on training from trained ergonomic personnel or immediate supervisor prior to being placed in a full-production position. The initial orientation will include:

[1] A demonstration of the proper use and care of, tools and equipment.

[2] Use of safety equipment.

[3] Use of safe and proper work procedures, such as proper lifting techniques.

13. Ergonomics Program Evaluation. Evaluations of PLFA, SLFA or other ergonomics programs may be performed by external or internal sources to assess program effectiveness.

a. External evaluations

(1) Occupational Safety and Health Administration (OSHA) inspections could result in citations to the commander for ergonomic deficiencies that are identified in the workplace.

(2) DLA or a PLFA may request USACHPPM or other Service/Agency:

- (a) Conduct ergonomics surveys at activities.
- (b) Evaluate elements of ergonomics programs.
- (c) Assist with ergonomics program development.

b. Internal evaluations. The PLFA EO ensures evaluation of the ergonomics effort regarding program participation and effectiveness. Examples of methods to measure both of these elements are listed below.

(1) Program participation.

(a) Number of requests for ergonomic assistance by management occurring during a specified period.

(b) Number of personnel suggestions related to ergonomics during a specified period.

(c) Number of educational programs in ergonomics offered.

(d) Number of personnel attending educational programs.

(2) Program effectiveness.

(a) Number of general or systematic identifications of potential WMSDs (e.g., the Nature of Injury Codes in SHIRS).

(b) Number of detailed analyses conducted ([paragraph 9.c., Detailed Analysis](#)).

(c) Number of high priority listings relating to ergonomics.

(d) Change in the incidence rate (i.e., new cases per 100 worker-years per year) of ergonomically related FECA claims or dollar amount of new FECA claims within a particular period.

(e) Change in the incidence rate of ergonomically related illness or injury reports filed for civilian personnel.

(f) Change in the incidence rate of ergonomically related illness or injury by department or unit.

(g) Change in the incidence rate of lost- or restricted-duty time due to ergonomically related illness or injury.

(h) Change in the number of new job reassignments due to ergonomically related illness or injury.

(i) Change in productivity or production costs that can be attributed to ergonomic interventions. (NOTE: In some cases, there may be an increase in illness or injury reporting at the start of an ergonomics program due to increased personnel and supervisor awareness. This reporting rate will decrease as a well-managed, effective ergonomics program is integrated into the workplace.)

c. Regular internal evaluation and review.

(1) The PLFA EO and the ergonomics committee will:

(a) Conduct at least a semiannual program evaluation and review.

(b) Present the results of this program evaluation and review to the SOH Council.

(c) Communicate the results of the program evaluation and review to top management and personnel.

(2) The program evaluation assesses the implementation, progress, and effectiveness of the installation ergonomics plan. It should include:

(a) A summary in-progress report or program update.

(b) A summary of results of external evaluations as defined in [paragraph 13.a.](#)

(c) Program participation and effectiveness measures defined in [paragraph 13.b.](#)

(d) Plans, goals, and accomplishments for the program as a whole and by the critical program elements cited in [paragraph 8.c.\(1\)\(c\)](#).

- (e) Identification of trends, deficiencies, and corrective actions needed.
- (f) New or revised program goals, priorities, and time lines.
- (3) Use the following information to develop the evaluation and review.
 - (a) Analysis of trends in injury or illness rates according to:
 - [1] Health care facility sign-in logs.
 - [2] Log of Federal Occupational Injuries and Illnesses or an equivalent log in SHIRS.
 - (b) Review results of installation evaluations.
 - (c) Before and after surveys or evaluations of workstation improvements.
 - (d) Observation of work practices to determine the effect of training and education.
 - (e) Personnel surveys or interviews conducted by department, job title, or workstation to monitor trends.

14. Technical reference library. SOHOs and EOs should consider maintaining a copy of the following technical references to support their ergonomics program.

- a. ANSI Z-365 (Working Draft). American National Standards Institute. (1996) Control of Work-Related Cumulative Trauma Disorders, Part 1 Upper Extremities. National Safety Council (NSC), Itasca, IL. (Available at cost from NSC, P.O. Box 558, Itasca, IL 60143-0429.)
- b. USACHPPM Technical Guide (TG) 220 (Draft). Ergonomics in Action. U.S. Army Center for Health Promotion and Preventive medicine and the U.S. Army Safety Center.
- c. Chapanis, A., 1991. To Communicate the Human factor 6 Message, You Have to Know What the Message Is and How to Communicate It. Human Factors Society Bulletin, Vol. 34 (11): 1-4.
- d. Directorate of Civilian Personnel and Installation Safety. 1992 Supervisor's Guide to the Civilian Resource Conservation Program. (Available from the Directorate of Civilian Personnel and Installation Safety, Fort McPherson, Georgia.)
- e. Injury Compensation for Federal Employees a Handbook for Employing Agency Personnel. US DOL, Office of Worker Compensation Programs (OWCP) Publication Number CA-810.
- f. Revised NIOSH Equation for the Design and Evaluation of Manual Lifting Tasks. (Available from NIOSH, 4676 Colombian Parkway, Cincinnati, OH 45226.)
- g. U.S. Department of Labor, OSHA. 1991. Ergonomics Program Management Guidelines for Meat Packing Plants, OSHA Publication #3123. (Available from U.S. Department of Labor, OSHA, 200 Constitution Ave., NW, N3651, Washington, DC 20210.)

Permit-Required Confined Spaces

1. Each DLA organization which conducts operations or has employees in operations involving permit-required confined space entry will develop and implement a written Permit-Required Confined Space Entry program and update the program at least annually per [29 CFR 1910.146 "Permit-required Confined Spaces"](#) (reference 18). The program shall contain, as a minimum, the requirements specified below in the marine vessel confined spaces and non-marine vessel permit spaces standards. The respective SOHO shall review and approve written permit-required confined space programs.
2. Marine Vessel Confined Spaces. Prior to entry into any confined space aboard a marine vessel, the space or spaces to be entered will be evaluated, inspected, and tested in accordance with requirements specified in National Fire Protection Association (NFPA) 306, Standard for the Control of Gas Hazards on Vessels (reference 34); and [29 CFR 1915.12, "Precautions and the Order of Testing Before Entering Confined and Enclosed Spaces and Other Dangerous Atmospheres,"](#) (reference 22) as they apply to the specific operation(s).
3. Non-Marine Vessel Permit Spaces. Prior to entry of any permit space, the space or spaces to be entered will be evaluated, inspected, and tested in accordance with the requirements specified in 29 CFR 1910.146 (reference 21) and 29 CFR 1926.353, "Ventilation and Protection in Welding, Cutting, and Heating" (reference 23), as they apply to general industry or construction standards.
4. Toxic Materials. The OSHA and ACGIH occupational exposure limits to toxic and hazardous materials in references 21, 22, 23, and 25 may vary from source to source. Therefore, DLA activities will comply with the lowest exposure limit for the toxic or hazardous materials of concern.
5. Definitions
 - a. Confined space. A space that:
 - (1) Is large enough and so configured that an employee can bodily enter and perform assigned work; and
 - (2) Has limited or restricted means for entry or exit (for example, tanks, vessels, silos, storage bins, hoppers, vaults, and pits are spaces that may have limited means of entry.); and
 - (3) Is not designed for continuous employee occupancy.
 - b. Entry. "Entry" means the action by which a person passes through an opening into a permit-required confined space. Entry includes ensuing work activities in that space and is considered to have occurred as soon as any part of the entrant's body breaks the plane of an opening into the space.

Personal Protective Equipment

1. Each DLA organization that conducts operations or has employees in operations that require the use of personal protective equipment shall establish and maintain a comprehensive and effective written Personal Protective Equipment (PPE) Program in compliance with [29 CFR 1910.132, "Personal Protective Equipment, General Requirements"](#) (reference 21), and [DoDI 6055.1, Enclosure 4, "DoD Personal Protective Equipment Program"](#) (reference 3). [Appendix B, Subpart I, of 29 CFR 1910.132](#) (reference 21) provides guidelines for controlling hazards, making hazard assessments and selecting PPE.
2. Supervisors shall ensure that:
 - a. Work conditions have been evaluated for PPE requirements. This includes providing a written certification to employees that identifies the workplace evaluated; the person certifying that the evaluation has been performed; and the date(s) of the hazard assessment. The written certification will be identified as a certification of hazard assessment. [interpretation](#)
 - b. Where PPE is required, employees are provided PPE at DLA expense. [interpretation](#)
 - c. Employees are trained on the proper use and care of PPE. Supervisors will certify in writing that the employee received and understood the required training, with the name of each employee trained, the date of training, and the subject of the certification.
3. Employees will use PPE required for each work condition.
4. Contractor Facilities. DLA personnel will follow PPE requirements at contractor facilities as required for the exposure.

Hazard Communication (HazCom)

1. Purpose. DLA Activities will inform their employees about the hazardous chemicals in their workplace so the employees can minimize their own exposures.

2. Requirements

a. Written Program. DLA activities will establish and maintain a written HAZCOM Program that meets the requirements of [DoD Instruction 6050.5, "DoD Hazard Communication Program"](#) (reference 5), and [29 CFR 1910.1200, "Hazard Communication"](#) (reference 21).

b. Hazardous material listing. DLA activities will maintain a current listing of hazardous material used in each work place.

c. Material Safety Data Sheets (MSDSs). DLA activities will maintain employee access to MSDSs for hazardous materials used in the workplace. MSDSs may be provided in paper or electronic media, as long as the employee can access the MSDS without major barriers during their work shift.

d. Training. DLA activities will train employees to safely use hazardous materials, and in the content of the hazard communication program.

3. Contractor Facilities. DLA Activities in contractor facilities will establish procedures with the contractor to use the contractor's hazard communication program wherever possible.

Powered Industrial Truck Operator Training

1. Purpose. The purpose of this program is to prevent injuries and damage from using powered industrial trucks (PITs) by requiring training and certification in the operation of PITs. OSHA has found that operating PITs (such as forklifts) is the second leading cause of fatalities in private companies (after highway vehicle accidents).

2. Definition. Powered industrial truck (PIT). Fork trucks, tractors, platform lift trucks, motorized hand trucks, and other specialized industrial trucks powered by electric motors or internal combustion engines. Does not include compressed air or nonflammable compressed gas-operated industrial trucks, nor farm vehicles, nor vehicles intended primarily for earth moving or over-the-road hauling. interpretation

3. Requirements. DLA activities will follow the requirements of 29 CFR 1910.178(a), "Powered Industrial Trucks" (reference 21), to train PIT operators. PIT operators must be trained and certified on each PIT type operated, and on each operating location. The amount and type of training should be based on the operator's prior knowledge and skill, the types of powered industrial trucks the operator will operate in the workplace, the hazards present in the workplace, and the operator's demonstrated ability to operate a powered industrial truck safely.

a. Training format. Training shall consist of a combination of formal instruction (e.g., lecture, discussion, interactive computer learning, video tape, written material), practical training (demonstrations performed by the trainer and practical exercises performed by the trainee), and evaluation of the operator's performance in the workplace.

b. Trainer requirements. All operator training and evaluation shall be conducted by persons who have the knowledge, training, and experience to train powered industrial truck operators and evaluate their competence. The trainer is the designated person to certify operator competency.

c. Required training topics by type of PIT operated:

(1) all operating instructions, warnings and precautions for the types of trucks the operator will be authorized to operate;

(2) similarities to and differences from the automobile;

(3) controls and instrumentation: location, what they do and how they work;

(4) power plant operation and maintenance;

(5) steering and maneuvering;

(6) visibility (including restrictions due to loading);

(7) fork and attachment adaptation, operation and limitations of their utilization;

(8) vehicle capacity;

(9) vehicle stability;

(10) vehicle inspection and maintenance;

(11) refueling or charging, recharging batteries;

(12) operating limitations; and

(13) any other operating instruction, warning or precaution listed in the operator's manual for the type vehicle which the employee is being trained to operate.

d. Required training topics by type of location where PIT is operated

(1) surface conditions where the vehicle will be operated;

(2) composition of probable loads and load stability;

(3) load manipulation, stacking, unstacking;

- (4) pedestrian traffic;
- (5) narrow aisles and other restricted places of operation;
- (6) operating in hazardous classified locations;
- (7) operating the truck on ramps and other sloped surfaces that could affect the stability of the vehicle;
- (8) other unique or potentially hazardous environmental conditions that exist or may exist in the workplace; and
- (9) operating the vehicle in closed environments and other areas where insufficient ventilation could cause a buildup of carbon monoxide or diesel exhaust.

e. Additional training is required when:

- (1) the operator is involved in an accident or near-miss incident,
- (2) the operator has been observed operating the vehicle in an unsafe manner,
- (3) the operator has been determined during an evaluation to need additional training,
- (4) there are changes in the workplace that could affect safe operation of the truck, or
- (5) the operator is assigned to operate a different type of truck.

f. Avoidance of duplicative training. If an operator has previously received training in a required topic, and such training is appropriate to the truck and working conditions encountered, additional training in that topic is not required if the operator has been evaluated and found competent to operate the truck safely.

g. Certification. PIT operators will be certified for each type of PIT they operate. A designated person will evaluate operator competency as a part of initial and refresher training, and at least once every 3 years.

Certification includes:

- (1) name of the trainee,
- (2) the date of certification, and
- (3) signature of the person performing the training and certification.

h. Recordkeeping. Retain the current training materials and course outline or the name and address of the person who conducted the training if it was conducted by an outside trainer.

Enclosure 13
DLAI 6055.1

Ionizing Radiation

Each DLA organization, which conducts operations or has employees in operations involving occupational exposure to Ionizing Radiation, shall establish and maintain a comprehensive and effective written Ionizing Radiation Program that complies with [DoD Instruction 6055.8, "Occupational Radiation Protection Program"](#) (reference 11).

Blood-Borne Pathogens

1. Purpose: DLA will protect employees who could be "reasonably anticipated," as a result of performing their job duties to face contact with blood and other infectious materials. DLA will follow the requirements of [29 CFR 1910.1030, "Bloodborne Pathogens"](#) (reference 21), as outlined in this enclosure.
2. Scope
 - a. OSHA's bloodborne pathogen rule applies to those people who are trained in CPR and first aid ([see enclosure 7, paragraph 5.a.\(4\)](#)), and are expected to provide assistance in an emergency, and any other employees who may be exposed to bloodborne pathogens as part of their job duties (such as, but not limited to, nurses, EMTs, ambulance drivers).
 - b. Infectious materials include semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid visibly contaminated with blood and all body fluids in situations where it is difficult or impossible to differentiate between body fluids. They also include any unfixed tissue or organ other than intact skin from a human (living or dead) and human immunodeficiency virus (HIV)-containing cell or tissue cultures, organ cultures and HIV or hepatitis B (HBV)-containing culture medium or other solutions as well as blood, organs or other tissues from experimental animals infected with HIV or HBV.
3. Exposure Control Plan. DLA activities will develop a written plan identifying tasks and procedures as well as job classifications where occupational exposure to blood or other infectious material occurs -- without regard to personal protective clothing and equipment. The plan will also specify the procedure for evaluating circumstances surrounding exposure incidents. The plan must be accessible to employees and available to OSHA. Activities must review and update the plan at least annually and as necessary to accommodate workplace changes.
4. Exposure Control. DLA activities will develop universal precautions, (treating body fluids/materials as if infectious) emphasizing engineering and work practice controls. [29 CFR 1910.1030 \(reference 21\) identifies specific exposure control procedures.](#)
5. Protective Equipment. DLA activities will provide, at no cost, and require employees to use appropriate personal protective equipment such as gloves, gowns, masks, mouthpieces and resuscitation bags and must clean, repair and replace these when necessary. DLA will provide non-latex gloves at no cost to employees with latex allergies. Gloves are not necessarily required for routine phlebotomies in volunteer blood donation centers but must be made available to employees who want them.
6. Cleaning procedures. DLA activities will develop a written schedule for routine cleaning, identifying the method of decontamination to be used, in addition to cleaning following contact with blood or other potentially infectious materials. Contaminated laundry will be handled in a manner which minimizes exposures.
7. Hepatitis B Vaccination. Vaccinations will be made available to all employees who have occupational exposure to blood or other infectious material within 10 working days of assignment, at no cost, at a reasonable time and

place, under the supervision of licensed physician/licensed healthcare professional and according to the latest recommendations of the U.S. Public Health Service (USPHS) or CDC. Vaccinations are not required to be provided where the employee has previously received the complete hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons. Employee participation in prescreening will not be required as a condition of receiving the vaccine. Employees must sign a declination form if they choose not to be vaccinated, but may later opt to receive the vaccine at no cost to the employee. Should booster doses later be recommended by the USPHS, employees must be offered them. [CDC Hepatitis B Guidelines](#)

8. Post-Exposure Evaluation and Follow-Up. DLA activities will evaluate suspected exposures to bloodborne pathogens to determine appropriate follow-up and treatment. Follow-up must include a confidential medical evaluation documenting the circumstances of exposure, identifying and testing the source individual if feasible, testing the exposed employee's blood if he/she consents, post-exposure prophylaxis if recommended by a licensed health-care provider, counseling and evaluation of reported illnesses. Healthcare professionals must be provided specified information to facilitate the evaluation and their written opinion on the need for hepatitis B vaccination following the exposure. Information such as the employee's ability to receive the hepatitis B vaccine must be supplied to the employer. All medical diagnoses must remain confidential.

9. Hazard Communication. Containers of regulated waste, refrigerators and freezers and other containers which are used to store or transport blood or other potentially infectious materials will be affixed with warning labels including the orange or orange-red biohazard symbol. Red bags or containers may be used instead of labeling. When a facility uses universal precautions in its handling of all specimens, labeling is not required within the facility. Likewise, when all laundry is handled with universal precautions, the laundry need not be labeled. Blood that has been tested and found free of HIV or HBV and released for clinical use, and regulated waste which has been decontaminated, need not be labeled. Signs must be used to identify restricted areas in HIV and HBV research laboratories and production facilities.

10. Information and Training. Employees at risk of exposure to bloodborne pathogens will be trained in program requirements initially upon assignment and annually. Training must include making accessible a copy of the regulatory text of the standard and explanation of its contents, general discussion on bloodborne diseases and their transmission, exposure control plan, engineering and work practice controls, personal protective equipment, hepatitis B vaccine, response to emergencies involving blood and infectious materials, how to handle exposure incidents, the post-exposure evaluation and follow-up program, and signs/labels/color-coding. There must be opportunity for questions and answers, and the trainer must be knowledgeable in the subject matter. Laboratory and production facility workers must receive additional specialized initial training.

11. Recordkeeping.

a. Medical records will be kept for each employee with occupational exposure for the duration of employment plus 30 years ([DoDI 6055.5](#), reference 7; [29 CFR 1910.1020](#), reference 21), must be confidential and must include name and social security number; hepatitis B vaccination status (including dates); results of any examinations, medical testing and follow-up procedures; a copy of the healthcare professional's written opinion; and a copy of information provided to the healthcare professional. Medical records must be made available to the subject employee, anyone with written consent of the

employee, OSHA, and NIOSH. Medical records will not be made available to the employer except as approved by the employee. Disposal of records must be in accordance with OSHA's standard covering access to records.

b. Training records must be maintained for 3 years and must include dates, contents of the training program or a summary, trainer's name and qualifications, names and job titles of all persons attending the sessions.

Enclosure 15
DLAI 6055.1

Traffic Safety

Field Activities will directly implement the requirements of [DoDI 6055.4, "DoD Traffic Safety Program"](#) (reference 6).

Enclosure 16
DLAI 6055.1

Radiofrequency Radiation

DLA activities will follow [DoD Instruction 6055.11, "Protection of DoD Personnel from Exposure to Radiofrequency Radiation and Military Exempt Lasers"](#) (reference 12), and standards and procedures of the DoD Component installation in protecting DLA personnel from hazards of radio frequency radiation.

Interpretations of DLAI 6055.1
by Paragraphs

- A. REFERENCES.
B. PURPOSE.

Question or Comment	Answer
Are the references referring to the OSHA Act or to the references in enclosure 1?	The numbered list of references refers to all of the documents previously described in this sentence.

- C. APPLICABILITY AND SCOPE.

Question or Comment	Answer
Specialized Safety. What is the relationship between the SOH Program and Specialized Safety Program?	Activities carried out as part of Specialized Safety were excluded from this Instruction because the purpose of the Specialized Safety Program is to ensure contractor compliance with contract terms, while the purpose of the SOH Program is to protect DLA personnel and resources [see definition for Specialized Safety]. Personnel performing both Specialized Safety and SOH activities will need to refer to the respective policies for those programs. DCMC will coordinate the activities of these two programs [paragraph E.2.c.].
Non-DLA Personnel. DLA can not mandate safety management principles to personnel from other DoD agencies who have their own program management.	This instruction also applies to non-DLA personnel, military and civilian, who are on DLA controlled or occupied facilities to the extent to which DLA is responsible for providing workplaces and operations free of recognized hazards.

- D. DEFINITIONS.

Question or Comment	Answer
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<p>Additional Duty Safety Monitors. Since we have employees who are called additional duty safety/PATT team members/etc., and work with supervision at the section level, I believe that these individuals provide a different type of support vs those collateral duty (or ADSM as DLA calls them) who manage the depots program and provide support to their Commander/supervisor. I believe that there is a distinct difference in each of their roles and needs to be identified. Yes, each of their primary duties are not SOH but each have different duties as additional and/or collateral duty safety.</p>	<p>This instruction has streamlined the terminology to 2 levels of duty –full time and part time. Full time are Safety and Occupational Health Officials (SOHOs); part time are additional duty safety monitors (ADSMs).</p>
<p>Incidence Rate. Not sure how they will determine new cases over a 12 month period especially when there is a multitude of late submittal of CA forms, changes from first aid to lost time, etc., coming in sporadically. What is DLAs definition of a new case? i.e. late submission, change to lost time, OWCP denial of a claim, etc. Is late considered new?</p>	<p>Updating data with late reports is acceptable practice. The SHIRS workgroup has developed procedures for revising incidence rates as late data is reported.</p>
<p>Safety and Occupational Health (SOH). Why use the term “SOH” instead of the OSHA term “OSH”?</p>	<p>The term “SOH” has been used instead of “OSH” to include those areas of safety which may not be currently addressed by OSHA standards, but which are within the scope of DoD safety programs (e.g. traffic safety).</p>
<p>Safety and Occupational Health Professional. Why does the list of Safety and Occupational Health Professional differ from the OPM guidelines for a Safety and Occupational Manager/Specialist (GS-018).</p>	<p>The definition is intended to identify all SOH job series. The listing is extracted directly from the 29 CFR 1960.2 definition for a “Safety and Health Specialist”.</p>
<p>Safety and Occupational Health Professional. This is already clearly defined in 29 CFR 1960, why is it considered necessary to repeat this material here?</p>	<p>Definition included here to get the info into the field's usable guidance without reference somewhere else - a piece that should be in use constantly.</p>

E. PROCEDURES.

1. GOALS AND OBJECTIVES.

a. HQ DLA.

Question or Comment	Answer
Goals and Objectives. Have the DLA SOHO provide goals and objectives to PLFAs annually for review and comment as well as the unions.	HQ DLA goals and objectives will be developed in conjunction with PLFAs.
Goals and Objectives. How does DLA intend to track abatement of OSHA citations?	Field activities will enter OSHA inspections and hazards they identify, along with inspections and hazards identified by DLA SOH professionals.

- b. FIELD ACTIVITY COMMANDERS AND ADMINISTRATORS.
- 2. DLA PERSONNEL AT CONTRACTOR FACILITIES OR WORK SITES.
- 3. SAFETY AND OCCUPATIONAL HEALTH COUNCILS (SOHCs).
- 4. PROGRAM OVERSIGHT.

Question or Comment	Answer
Satisfactory Rating. What does it take to get a satisfactory rating? Is this something that is determined by the PLFA or DLA? If DLA, what is the criteria for a satisfactory rating?	Rating procedures are currently too fluid to record in the instruction. If procedures are stable and well accepted, than we can include in a future instruction.
Oversight for Overseas Organizations. Recommend the following sentence be added, "Safety and Health Officials at HQ DLA-Europe and HQ DLA-PACAF will provide annual evaluations of the overseas organizations for the stateside PFLAs except for DCMC organizations, unless otherwise agreed to. Coordination between the Safety and Health Officials is emphasized to ensure the evaluations meet the needs of the stateside PFLAs. Copies of all reports will be provided to the PFLAs Safety and Health Office. These procedures, however, do not restrict the PFLA SHO from visiting their overseas locations as necessitated by situations requiring their presence".	PLFAs were assigned responsibility for oversight of their subordinate activities' SOH programs, regardless of geographic location, to keep responsibilities within the chain of command. PLFAs were allowed to arrange for oversight by another organization which is physically closer, but the PLFAs retain responsibility for funding oversight activities and for correcting the problems identified. Specific geographic arrangements were not addressed in this Instruction due to the ongoing organizational changes.

- 5. FEDERAL AND NONFEDERAL SAFETY AND HEALTH ORGANIZATIONS.
- 6. SAFETY AND HEALTH CONFERENCES.
- 7. DoD POSTER.
- 8. ISAs, MOUs, and CONTRACTS.

Question or Comment	Answer
<p>Review Level for ISAs. Should SLFAs review ISAs?</p>	<p>Emphasis added to have DLA contracting and procurement offices work with PLFA SOHO. Prefer coordination with PLFAs rather than SLFAs because experience is more consistently available at PLFAs to review procurements.</p>

9. ADDITIONAL PROGRAM SUPPORT.

10. STANDARDS.

a. BASIC SOH STANDARDS.

Question or Comment	Answer
<p>State and Local Regulations. DLAD 6055.1 requires us to comply with state and local regulations, but this Instruction doesn't.</p>	<p>OSHA and DoD do not require DLA to comply with state and local SOH standards. The compliance requirement will be deleted in the next update to DLAD 6055.1. Keeping this requirement would require DLA to stay current and comply with 20+ state plans for state-unique standards (e.g. California rule on ergonomics). DLA Field Activities will still be protected to the more stringent of DLA and host activity standards. In those instances where contractor facilities are complying with more protective state/local standards, then DLA employees would be protected to the state/local standards by virtue of working in the contractors' facilities.</p>

b. DLA SUPPLEMENTARY STANDARDS.

Question or Comment	Answer
<p>Who else is using ACGIH TLVs? Why not just stay with OSHA PELs?</p>	<p>Army & Air Force have also adopted the ACGIH TLVs as Component standards. ACGIH TLVs respond faster to the latest toxicology information than OSHA PELs.</p>

c. ALTERNATE OSHA STANDARDS

d. JOINT USE FACILITIES.

e. CONTRACTOR STANDARDS DURING NATIONAL EMERGENCIES.

11. HAZARD DETECTION, REPORTING, AND ABATEMENT

a. INSPECTIONS

Question or Comment	Answer
Employee Representatives. It is not the role of DLA Safety personnel to encourage or discourage local employee representatives from participating in inspections.	Encouraging employee representative participation builds good relations with labor.
Tracking Hazards. Why use DLA forms locally & SHIRS by SOHOs?	DLA form 1691, Hazard Abatement Log, and 1404a, Hazard Report Log, provide information that is needed to track hazards in SHIRS. The SOHO is not required to assign RACs, but is allowed to work with the host safety office to ensure a RAC was assigned

- b. FEDERAL OSH INSPECTIONS or INVESTIGATIONS
- c. EMPLOYEE HAZARD REPORTING AND RESPONSE SYSTEM.
 - (1) REPORTING.
 - (2) INVESTIGATIONS.
 - (3) RESPONSE.
- d. HAZARD ABATEMENT.

Question or Comment	Answer
Imminent Danger. As written, DLA's definition of imminent danger excludes hazards having a severity of and a probability of B. Yet per DOD 6055.1 (8/19/98) these are also defined as critical.	The definition for "imminent danger" is extracted directly from DoDI 6055.1. It defines the subset of RAC 1 hazards (category I-A and II-A) where a commander is required to stop work. "Imminent danger" excludes RAC 1 category I-B. "Critical" is the descriptor for all RAC 1 hazards (category I-A, II-A, I-B).

- e. PROTECTION AGAINST REPRISAL.
12. EDUCATION AND TRAINING.
- a. EMPLOYEES
 - (1) GENERAL TRAINING.

Question or Comment	Answer
Are supervisors personally required to perform training, or can they arrange for the training?	Supervisors are not required to personally perform the training – only to ensure the training has been provided

- (2) LOCAL AREA HAZARD SAFETY BRIEFING.

Question or Comment	Answer
<p>Local Area Hazard Safety Briefing. Delete this briefing requirement. This requirement will be almost impossible to implement within the continental United States and would be of limited benefit. For any overseas DLA activities it would be useful.</p>	<p>This briefing is required by DoDI 6055.1 where local hazards exists. If there are no unique local area hazards, then a local area hazard safety briefing is not required</p>

- (3) TASK TRAINING.
- (4) Recording Training.

Question or Comment	Answer
<p>How will an employee's SOH training be recorded?</p>	<p>SOH training will be recorded in each employee's personnel file on the SF7B.</p>

- b. SUPERVISORS.
 - c. COMMANDERS.
 - d. Recognized employee representatives
 - e. SOHOs
 - f. ADSMs.
- 13. Traffic Safety.
 - 14. Radio Frequency Radiation.
 - 15. Field Activities will comply with the specific program requirements detailed in enclosures 2 through 16.

F. RESPONSIBILITIES.

- 1. HQ DLA
 - a. The Director will:

Question or Comment	Answer
<p>Why doesn't the DLA Director issue an annual safety statement?</p>	<p>The Director is a military member who changes every few years. The safety statement is reissued with each new Director.</p>

- b. The DASHO will:

Question or Comment	Answer
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<p>Responsibilities of DASHO vs. HQ DLA SOHO. It appears that the DASHO has basically two specific things he or she will be doing and that another position as DLA Safety and Occupational Health Manager is in being to perform the other functions. So, if I understand this correctly there will be a Director and two Managers in the DLA Safety Office.</p>	<p>DASHO and HQ DLA SOHO are separately identified in 29 CFR 1960. The DASHO has overall responsibility for the program, and must be at least at the Assistance Secretary level for the federal agency. The DASHO appoints the SOHO to carry out daily SOH Program functions.</p>
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- c. The HQ DLA Safety and Occupational Health Official (SOHO).
 - d. HQ Executive Directors, Staff Directors, Chiefs, Office Heads, and Program Managers
2. DLA Field Activities
- a. PLFA and Installation Commanders and Administrators
 - b. Field Activity SOHOs

Question or Comment	Answer
<p>This instruction appears to put a lot of responsibilities on the commanders and supervisors rather than the SOHO.</p>	<p>SOH responsibilities have been worded throughout the Instruction to state that commanders/directors/supervisors are responsible for the SOH program, and that SOHOs and ADSMs serve as their SOH technical advisors and assistants. SOHOs are also technical advisors to ADSMs, but do not supervise the ADSMs. Commanders/directors assign ADSMs when they decide the SOH workload does not warrant a full time SOHO</p>

- c. Supervisors at all levels

Question or Comment	Answer
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<p>It appears that supervisors are being tasked with performing the investigation(s) of all work related mishaps, injuries, illnesses. In reading through the duties of "Field Activity SOHOs" there is nothing written that requires/suggests/infers them to perform any accident investigations. Item b(7) under "SOHOs" indicates "Provide technical guidance and support to ADSMs within their organization" which, if interpreted could mean providing guidance on how to conduct investigations. If I am reading correctly and investigations are now the responsibility of supervision, we will have considerable problems convincing management of this requirement, since their main priority is staying alive with the few supervisors they have left to get the job done. Duties of "Field Activity SOHOs" must include conducting and/or assisting supervision in the investigation of job-related accidents. We need to also think about providing every supervisor with accident investigation training, since there are many out there who do not/cannot/don't know how to conduct an investigation. We need to be involved in investigating every lost time accident - at least making it a joint venture with supervision/employee rep/etc., so that we can ensure that all of the info needed is available, documented, and input to SHIRS.</p>	<p>While formal accident investigations may in fact be accomplished by safety professionals, there is no reason to remove the basic requirement of supervisors to immediately find out what happened to the people who work for them--that is what is intended and meant by supervisory responsibility for accident investigation in this area. Most accidents, especially those involving injuries, need this basic information gathered immediately, long before most safety pros can arrive on the scene--indeed, in most of the agency, safety pros could never get to the actual scene most of the time.</p>
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- d. Additional Duty Safety Monitors (ADSMs).
- e. Employees
- f. DLA Contracting and Procuring Officials

<p>PLFA Notified for Contract Reviews. How will PLFAs get to see all of the various procurement contracts?</p>	<p>The basic policy requirement is established in this Instruction. HQ DLA will work to establish procedures within the Instructions guiding DLA internal procurement, similar to current procedures for reviewing MSDSs for hazardous materials.</p>
<p>Scope of Contract Reviews. Are PLFAs required to review contracts for which Specialized Safety is performing inspections?</p>	<p>PLFAs SOHOs will review contracts for materiel & services delivered to DLA. Reviewing contracts for materiel & services to other DoD Components is a responsibility of the Specialized Safety program – not PLFA SOHOs.</p>

G. EFFECTIVE DATE.

H. INFORMATION REQUIREMENTS.

Enclosures 1, References

Enclosure 2, Hearing Conservation

Question or Comment	Answer
<p>Enclosure 2, Hearing Conservation, reiterates requirements of DoDI 6055.12. Why are we wasting paper if we are following the Purpose of the instruction and implementing DoD instructions.</p>	<p>DoDI 6055.12 allows DoD Components to use either a 3 dB or 4 dB exchange rate. The enclosure is needed to establish the DLA noise measurement standard of a 3 dB exchange rate. Also, policy is provided to address when DLA is a tenant on military installations (Navy vs. Army & Air Force). Readers are referred to DoDI 6055.12 for program execution details.</p>

Enclosure 3, Mishap and Hazard Reporting

1. PURPOSE.
2. POLICY.
3. MISHAP REPORTING PROCEDURES.
4. SPECIAL REPORTING OF SERIOUS MISHAPS.
5. HAZARD REPORTING PROCEDURES.

Enclosure 4, Industrial Hygiene Program

1. PURPOSE.
2. WORK PLAN.

Question or Comment	Answer
<p>As the paragraph is now written, an IH work plan is not required to be prepared. But if someone does make one then they have to follow a specific format. This does not make sense because it discourages people from making an IH work plan in the first place. Either make such a plan and all its sub elements mandatory or eliminate the mandatory sub-element requirements.</p>	<p>Minimum requirements are provided to guide in developing a work plan. Additional items may be included.</p>

3. WORKPLACE SURVEYS.

Question or Comment	Answer
<p>Investigate Workers' Compensation Claims. It appears that this is a new requirement for IHs to investigate comp claims because I checked with one and he has not heard of this requirement and has not been accomplishing this in the past. If indeed this will be tasked to DLA IHs, what about the IHs that provide us service via an ISA? Presently, we have only one IH assigned throughout the DDC other than those that provide services from the host. Will the host IHs be required to adhere to this requirement? What about specialized training for IHs to be able to accomplish an investigation? It appears that with the newly revised supervisory mishap report, safety professionals have been cut out of the investigative process other than receiving the completed form from a supervisor and then asking questions.</p>	<p>Policy allows for the possibility of locations and situations where IH availability is limited or non-existent. Where IH service available, it should be utilized to maximum extent possible to improve the quality of information which can be used to accurately assess compensation claims and possible preventive occurrences/exposures in the future.</p>

4. RECORD KEEPING.

5. REPORTING.
 - a. SURVEY REPORT.

Question or Comment	Answer
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Reports to Whom? Will IH provide survey reports to line manager or the SOHO?	IH will provide reports to the SOHO for the workplace surveyed.
Using SHIRS. Is the IH expected to use SHIRS if another automated system is used by host medical personnel? If not, then how do you plan to share this information with the SOHO?	IH will use SHIRS to record hazard and inspection data so that health & safety hazards are available in one location. IH will use other automated systems for IH exposure data. DoD is developing a standard IH information management system – Defense Occupational Health Readiness System (DOHRS) IH. However, we cannot mandate its use until it is fielded and available to DLA hygienists. Until DOHRS IH is fielded, hygienists are encouraged to use the same system as host medical personnel.

- b. MEDICAL SURVEILLANCE.
- 6. EQUIPMENT CALIBRATION.
- 7. PLANS REVIEW.

Question or Comment	Answer
Results to Whom?. To whom does the IH report recommended changes to facilities and operations to ensure health hazard controls are designed into all new operations.	Such reviews will be brought to the attention of the SOHO for appropriate action with the responsible parties.

Enclosure 5, Occupational Medicine Services

- 1. PURPOSE.

Question or Comment	Answer
Who Arranges for OccMed Services? It is the responsibility of the Commander to arrange for occupational medicine services to be provided. How this is coordinated and by whom on the Commander's staff varies greatly. If you mandate that the SOHO will do this when he does not necessarily have the authority to do it you will have problems. Suggest that this should be coordinated with or through the SOHO.	Agree

- 2. Confidentiality of medical data

3. Examinations
 - a. Medical Surveillance for Workplace Exposures.
 - b. Fitness and Risk Determination.
 - c. Pregnancy Surveillance.
 - d. Administrative examinations or evaluations
 - e. Employee Participation.
4. Medical Treatment
 - a. Emergency medical treatment.
 - b. Non-emergency medical treatment.
 - c. Treatment of non-occupational medical conditions.
 - c. Flu immunizations
 - d. Travel immunizations.
5. Education.

Enclosure 6, Ergonomics

1. Purpose.
2. Scope.
3. Responsibilities.
 - a. PLFA Commanders
 - b. The SOHO:

Question or Comment	Answer
<p>Access to Medical Records. Not sure if we are privy to receiving copies of medical records, whether sanitized or not. This may vary at each of the depots and must be coordinated with the host prior to assuming that we are entitled to receive these reports.</p>	<p>Agree that you will need to coordinate procedures with the Medical Department regarding access to medical records.</p>

- c. Medical Staff:
- d. The PLFA EO:
- e. The ergonomics committee:
- f. Trained ergonomics personnel
- g. Industrial hygiene (IH) personnel:
- h. PLFA safety personnel trained in ergonomics:
- i. Medical and occupational health care personnel trained in ergonomics
- j. The Human Resources Customer Support Unit (CSU) staff:
- k. The chief of equipment contracting, or equivalent:
- l. The Chief of Facilities Management or equivalent:
- m. The chief of logistics operations, installation engineering support or
- n. Recognized employee representatives:
- o. The supervisor:
- p. Employees:

4. Technical support.
5. Ergonomics Program Goals
6. Organizational involvement.
7. Effects of work-related musculoskeletal disorders
8. Occupational risk factors
9. Ergonomics Program Plan.
10. Worksite Analysis
11. Hazard Prevention and Control
12. Health Care Management
13. Education and Training
14. Ergonomics Program Evaluation.
 - a. External evaluations
 - b. Internal evaluations.
 - c. Regular internal evaluation and review
15. Technical reference library.

Enclosure 7, Permit Required Confined Spaces

1. General.
2. Marine Vessel Confined Spaces.
3. Non-Marine Vessel Permit Spaces.
4. Toxic Materials.
5. Definitions
6. General Requirements.
 - a. Evaluating confined spaces.
 - b. Permit Space Assessment and Certification.
 - c. Entry Authorization Certificate.
 - d. Sampling Equipment.
 - e. Permit Space Environment..
 - f. Entry Precautions.
 - g. Personal Protective Equipment (PPE).
 - h. Respiratory Protection.
 - i. Training.
 - j. Emergency Rescue..
 - k. Communications..

Enclosure 8, Personal Protective Equipment

1. Purpose
2. Supervisors shall ensure that

Question or Comment	Answer
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Work Condition Evaluation. Is there a requirement for how current the evaluation of work conditions should be?	There is no requirement for periodic re-evaluation, nor an expiration date for the initial evaluation.
Payment for PPE. Does DLA pay for shoes & safety glasses?	Providing all PPE at DLA expense exceeds the OSHA requirement, but is a good business practice for DLA to provide the PPE rather than debate the issue. Optional use PPE need not be provided at DLA expense.

3. Employees
4. Contractor Facilities.

Enclosure 9, Respiratory Protection

1. Purpose
2. Responsibilities
 - a. Respiratory Protection Program Administrator
 - b. Supervisors
 - c. Employees
3. Hazard Assessments
 - a. Workplace Evaluations
4. Selection and Use of Respiratory Protection.
5. Medical Evaluation
 - a. Initial Evaluation
6. Maintenance and Inspection of Respirators
7. Fit Testing and Face Seal Protection.

Question or Comment	Answer
Fit-testing Frequency. Re-testing by some regulations (asbestos and lead) are required every 6 months rather than annually.	There is no requirement for re-testing more frequently than annually in the OSHA standards for respiratory protection, lead, or asbestos.

8. Training
9. Program Evaluation
10. Recordkeeping

Question or Comment	Answer
Record keeping duration. Why keep records for five years when OSHA requires only the most recent records?	DLA experience with legal proceedings indicates the need to keep records longer to demonstrate past employee protection. We considered following medical record keeping requirements (30 years) but considered this excessive.

Enclosure 10, Hazard Communication (HazCom)

1. Purpose.
2. Requirements
 - a. Written Program.
 - b. Hazardous material listing.
 - c. Material Safety Data Sheets (MSDSs).
 - d. Training.
3. Contractor Facilities.

Enclosure 11, Powered Industrial Truck Operator Training

1. Purpose.
2. Definition

Question or Comment	Answer
Equipment Included. Are the warehouse lifts pulling supplies off of high shelves included?	We have interpreted the OSHA standard to include all of DLA's powered material handling equipment such as warehouse stacking & transporting equipment

3. Requirements.
 - a. Training format.
 - b. Trainer requirements.
 - c. Required training topics by type of PIT operated
 - d. Required training topics by type of location where PIT is operated
 - e. Additional training .
 - f. Avoidance of duplicative training.
 - g. Certification.
 - h. Recordkeeping.

Enclosure 12, Ionizing Radiation

Enclosure 13, Blood-borne Pathogens

1. Purpose:
2. CPR & first aid training.
3. Scope.
4. Exposure Control Plan:
5. Exposure Control.
6. Protective Equipment.
7. Cleaning procedures.

8. Hepatitis B Vaccination.

Question or Comment	<u>Answer</u>
Part-time Employees. What about summer lifeguards who are not employed long enough to complete the series or employees on temporary assignment of less than 6 months.	The OSHA standard does not remove the requirement for vaccination for part-time employees. OSHA interprets the standard to require continuation of hepatitis B vaccinations, even when delayed because the employee missed the scheduled immunization. We have interpreted this to indicate that part-time employees should also have vaccinations offered.

- 9. Post-Exposure Evaluation and Follow-Up.
- 10. Hazard Communication.
- 11. Information and Training.
- 12. Recordkeeping.

Enclosure 14, Traffic Safety

Enclosure 15, Radiofrequency Radiation