Healthcare Workers Flee from Flu Shots

Associations recommend mandatory vaccine programs for HCWs

As healthcare professionals, we brace ourselves each year for flu season. According to the Centers for Disease Control and Prevention, influenza-related illness and complications lead to more than 20,000 hospitalizations and 36,000 deaths each year. Many of those patients will start out in your waiting room—potentially infecting everyone they come into contact with, from your staff to other patients.

Why, then, do so few healthcare workers get a flu vaccine? At a dismal 36%, healthcare workers rank near the bottom of those who are immunized against influenza (see chart).

Why, then, do so few healthcare workers get a flu vaccine?
While the U.S. Public Health Service hasn’t made the leap towards mandatory flu vaccination for HCWs, it does strongly recommend influenza vaccination. In a February 9th Press Release, the CDC advised employers to offer free flu vaccine in the workplace to all eligible personnel (including students) during all shifts. Employees who refuse must sign a declination form (See Form 24 in Quality America’s OSHA Safety Program Manual).

Last fall, Seattle-area Virginia Mason Medical Center was the first to require its 5000+ employees to get flu vaccinations. Though the Washington State Nurses Association filed a grievance against “forcing” nurses to be vaccinated against the flu, at press time, about 96% of Virginia Mason workers, including nurses, had complied. About 1% were exempted for religious or medical reasons. Others who refused the flu vaccine quit or were fired.

With pandemics like avian flu in the news, talk of mandatory vaccines for HCWs is not a fly-by-night proposition. Without proper immunizations, the potential for an influenza pandemic exists, which could lead to more than 700,000 hospitalizations and 42 million outpatient visits. This translates into healthcare costs of up to $166 billion.

Consider making flu immunizations a requirement in your workplace, especially for those who have direct patient contact.

Sources:
2. Seattle Post-Intelligencer. Flu shot requirement won’t apply to nurses. Friday, January 6, 2006
Case Highlights Importance of Testing/Treating Employees with Positive PPDs

Nurse Exposes Hundreds of Patients to TB

Congratulations! You’ve just completed TB skin tests (TST) on all your employees.

There’s just one problem: one nurse tested positive. Now what should you do? The best course of action is to order a chest x-ray at your local health department. If the employee’s chest x-ray is negative, she has latent TB infection (LTBI), meaning that she has been exposed to Mycobacterium tuberculosis, but does not have active disease.

Should this and other workers with LTBI be treated? Yes, if they are at high risk of progressing to active TB disease, according to new Guidelines from the CDC (see Table 1). Treatment with rifampin or isoniazid (INH) reduces the risk that their infection will progress to TB disease.

Table 1. When TST result is >5 mm, regardless of age:

- Persons infected with HIV
- Persons born or who have lived in developing countries or countries with a high-incidence of TB disease
- Persons who inject illicit drugs
- Persons with conditions that place them at high risk for TB disease:
  - Silicosis
  - Diabetes mellitus
  - Chronic renal failure
  - Leukemias and lymphomas
  - Carcinoma of the head, neck or lung
  - Unexplained weight loss of >10% of ideal body weight
  - Gastrectomy or jejunoileal bypass
- Persons living in areas with high incidence of TB disease
- Children aged <4 years
- Infants, children and adolescents exposed to adults at high risk for developing TB disease

Table 2. When TST result is >10 mm:

- Persons with TST or TB blood test conversions
- Persons born or who have lived in developing countries or countries with a high-incidence of TB disease
- Persons who inject illicit drugs
- Residents and employees in congregate settings that are at high risk (i.e., correctional facilities, hospices and skilled nursing facilities), hospitals and other healthcare facilities, residential settings for persons with HIV/AIDS or other immunocompromising conditions, and homeless shelters
- Personnel from mycobacteriology laboratories
- Persons with conditions that place them at high risk for TB disease:
  - Silicosis
  - Diabetes mellitus
  - Chronic renal failure
  - Leukemias and lymphomas
  - Carcinoma of the head, neck or lung
  - Unexplained weight loss of >10% of ideal body weight
  - Gastrectomy or jejunoileal bypass
- Persons living in areas with high incidence of TB disease
- Children aged <4 years
- Infants, children and adolescents exposed to adults at high risk for developing TB disease

Table 3. When TST Result is >15 mm:

- Consider treating persons with no known risk factors

continued on next page
Your local public health department can determine whether treatment for an employee with LTBI is indicated. CDC recommends in the text of their Guidelines (but not in their Table, above) that HCWs should be offered treatment for LTBI.

Note: The health department can force someone with infectious TB into treatment; those with latent TB pose no immediate threat and therefore can be given only guidance and encouragement to undergo treatment.

Since 90% of people with LTBI never develop active TB, they are unlikely to submit to the 9-month course of medication that treatment requires. Fewer than one-quarter of healthcare workers eligible for TB treatment actually receive care.

The case of a TB-infected nurse in a New York City hospital demonstrates the adverse consequences when workers refuse treatment for LTBI. In September 2003, the nurse began showing symptoms of infectious pulmonary tuberculosis, including coughing, wheezing and shortness of breath. She continued to work for another two months before the illness was diagnosed and her contact with patients was cut off.

During that time, she exposed as many as 1,500 patients to TB and most likely infected at least four infants.

The nurse was aware she had had LTBI for 11 years, yet declined treatment, thinking that her positive test result was due to receiving the BCG vaccination as a child in the Philippines. CDC now says all HCWs - particularly those foreign-born or trained, including those who have been vaccinated with BCG - need to follow the latest U.S. guidelines for the treatment of LTBI (see Table 1).

After the nurse tested positive for pulmonary TB in December, the hospital and the health department spent 7 months trying to notify those at risk of exposure. They sent letters, visited homes, contacted doctors and tried to cross-reference the names of exposed infants with the city’s immunization registry.

More than 1,000 of the patients the nurse came in contact with could not be
found, but so far, the only patients known to have been infected are four infants, who were treated and are now healthy. So is the nurse.

This case underscores the importance of treating healthcare workers with LTBI to prevent TB disease and subsequent transmission. The case also highlights a challenge that increasingly worries public health officials: screening and treating foreign-born healthcare workers for tuberculosis.

**New TB Blood Test Promises to Reduce Confusion**

The new TB blood test, QuantiFERON®-TB Gold (QFT-G), is a better alternative to the purified protein derivative (PPD) tuberculin skin test (TST), since it avoids false positive results from people who received the BCG vaccine. It is also less likely to show false negative results for those with AIDS or other immune deficiencies.

Each QFT Gold test kit costs about $15, plus an additional $10 or so to administer. The skin test equipment is less expensive, but labor costs to get a result bring it to about the same price.

To reduce the confusion of PPD skin test results, instead consider using it the QFT-G for your employee skin testing program. Many health departments across the nation now use this test.

**Sources:**

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"Don’t think of it as getting a flu shot. Think of it as installing virus protection software."
OSHA Upholds Needlestick Fine

OSHA fined a nursing home a whopping $5,000 for not using add-on safety needles with pre-filled syringes. The nursing home appealed the case, stating that the Bloodborne Pathogens Standard was "unconstitutionally vague" as it pertains to safety needles.

It all began when a nurse at Genesis Eldercare was accidentally stuck after gesturing to another nurse who was holding a prefilled syringe without a safety needle. (Can’t you just picture this?) The second nurse had used the pre-filled syringe without first attaching an add-on safety needle, such as a needle guard, and then failed to immediately place the unprotected needle in a sharps container.

Once OSHA got their foot in the door, the nursing home was also cited for not training staff on how to use add-on safety needles. OSHA requires annual retraining, so when a nurse testified that training had been so long ago that it simply didn’t occur to her to look for and use the safety devices, fines began piling up. The employer didn’t have any records to prove otherwise.

Take-away lesson:
1. Provide add-on safety devices and require workers to use them.
2. Have records that workers have been initially trained on OSHA and annually thereafter.

MRSA: Coming Soon to a Clinic Near You

About 2 million people in the U.S., or 0.8% of the population, are estimated to carry methicillin-resistant Staphylococcus aureus (MRSA) in their nasal passages. MRSA is creating a health hazard in this country, dwarfing the threat posed by the H5N1 avian flu.

MRSA causes difficult-to-treat infections not only in hospitals, but also now in the general community, leading to concerns about widespread outbreaks of hard-to-treat microbes. Episodes of drug-resistant infections have occurred in the past year on professional U.S. football teams, including the St. Louis Rams, Baltimore Ravens and San Francisco 49ers.

Staphylococcus aureus infects about 300,000 hospital patients a year; around 40% is MRSA, and about 12,000 infected patients die.

Although pharmaceutical companies are searching for new antibiotics effective against MRSA, longer term solutions are under investigation by these same companies, such as staphylococcal vaccines.

Meantime, the Centers for Disease Control and Prevention is formulating new hospital rules to intensify sterilization requirements for health workers and increase testing of patients who may harbor dangerous germs. They may call for hospitals to create special quarantine wards.

Source: Journal of Infectious Diseases, January 15, 2006.

Errata
New TB Guidelines—Page 2

In our Jan/Feb issue of OSHA Watch, the lead story, “New TB Guidelines” omitted two symbols in the Annual Risk Assessment table on page 2. Please note the corrections in red. We apologize for this omission.

<table>
<thead>
<tr>
<th>Annual Risk Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk</td>
</tr>
<tr>
<td>&lt; 3 TB patients/year</td>
</tr>
</tbody>
</table>

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**CPR Rules Updated**

Cardiac arrest kills more than 250,000 people in the U.S. per year. In an attempt to reduce mortality from cardiac arrest, the American Heart Association (AHA) has issued new CPR procedures. Currently, about 95% of cardiac arrest victims die before reaching a medical center. AHA’s new guidelines simplify the CPR procedure and emphasize chest compression over mouth-to-mouth (see Table below). Earlier CPR rules varied according to the age of the victim and required rescuers to find and read a pulse. Now, AHA’s new guidelines standardize chest compression and ventilation for adults and children alike, and abandon practices such as taking a pulse.


<table>
<thead>
<tr>
<th>Old CPR</th>
<th>New CPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varied according to the age of the victim</td>
<td>Standardizes chest compression and ventilation for adults and children alike</td>
</tr>
<tr>
<td>Need to find and take a pulse</td>
<td>No need to take pulse</td>
</tr>
<tr>
<td>Pump chest 15 times, then blow into victim’s mouth twice for two seconds</td>
<td>Pump chest 30 times, then blow twice for one second</td>
</tr>
<tr>
<td>Give 3 stacked shocks from defibrillator</td>
<td>Give 1 shock from defibrillator before chest compressions for 2 minutes. Give another shock if necessary</td>
</tr>
</tbody>
</table>

**Drain Center Mishap Evacuates Medical Office**

Employees and patients at a Raleigh, N.C., internal medicine practice complained of nausea, headaches, and a rotten egg smell and were evacuated from the building as a precaution. The cause? Someone had poured drain cleaner into a clogged drain the night before, but the clog didn’t loosen, which sent fumes into the rest of the building during the night. No one suffered any injuries.

Lesson learned: Don’t underestimate the threat of everyday chemicals!


**Watch Children in Exam Rooms!**

A 3-year-old child tried to drink a cup of phenol that had been left sitting on a counter, but instead spilled it down the front of his face and chest, sustaining immediate pain and irritation to the lips, chin, chest and abdomen. An ENT resident had poured about 1 mL of phenol (89%) into a cup and placed it on the counter in an exam room where he was preparing to perform a myringotomy on the child’s mother. Phenol is used to anesthetize the tympanic membrane.

The child was allowed in the treatment room along with another family member who was supposed to be watching the child. The child still managed to grab the cup and place it to his lips before spilling its contents over his mouth and chest. The child had erythema and whitish areas of sloughed-off dead tissue (eschar) on the oral mucosa of his lower lip, chin, neck, anterior chest, and upper abdomen. The child also underwent an endoscopy and bronchoscopy to ensure there was no further harm to his airway and esophagus.

Since this accident, the facility stopped purchasing bulk phenol and now uses unit-dose phenol applicator kits to reduce the potential for unintended exposure to this harsh chemical. Also, children (unless being treated) are no longer allowed in treatment rooms.


**Proposed Bill Includes Fines for Employees**

U.S. Senator Mike Enzi (R-WY), Chairman of the Senate Health, Education, Labor, and Pensions Committee, recently introduced an employer-friendly legislative package that included a provision that would allow OSHA to fine employees who willfully violate rules regarding the use of company-supplied personal protective equipment. The Enzi bill also provides for the recovery of attorney’s fees by small businesses that prevail in lawsuits against OSHA and allows inspectors to waive penalties for non-serious violations if they are promptly corrected.

Source: The Occupational Safety Fairness Act S. 2066.11/22/2005

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continued on next page
**Teacher Sues Over Hep C Infection: Schools Not Exempt from BBP Regs**

After becoming infected with hepatitis C, a paraprofessional who works with “special needs” children in New York City's public school system is suing the Board of Education for failing to provide her with adequate education about and protection from bloodborne diseases. The teacher claims that she was infected from repeatedly coming into contact with the blood and feces of the children under her care. She describes how some of the students self-mutilate, bite, and can become very aggressive as part of their special condition.

She has been out of work without pay for more than 5 months and has had to endure 48 weeks of grueling treatment. She accused the school of ignoring standards about how to deal with blood. Educators are not being offered vaccines or being adequately trained. In most cases they get very little equipment—maybe a pair of latex gloves. After the woman's diagnosis, her school was found guilty of 14 violations, for which the Board of Education was fined tens of thousands of dollars.


**FDA Warns of Life-Threatening False Glucose Readings**

The FDA has warned healthcare professionals of the potential for life-threatening falsely elevated glucose readings in patients who have received parenteral products containing maltose or galactose, or oral xylose, and are subsequently tested using glucose monitors based on dehydrogenase pyrroloquinoline-quinone (GDH-PQQ) technology.

Do not test patients who have received such products with a method that is affected by these sugars (a list of these products can be found on the FDA’s website). Examples of methods that can produce erroneous results for these patients are GDH-NAD, glucose oxidase- or glucose hexokinase-based test methods. If in doubt, contact the glucose meter manufacturer.

On TB Tests for Employees

**Q.** For TB purposes, how do you define a healthcare worker (HCW)? Is it just those with direct patient contact (e.g., medical assistants and nurses) or does it include medical records and front desk receptionists?

**A.** HCWs are all paid and unpaid employees who have face-to-face contact with patients with suspected or confirmed TB disease. Include part-time, temporary, contract, and full-time HCWs in your TB screening program who meet this criteria. This would definitely include receptionists, but not medical records personnel, if patients with suspected TB were immediately transferred to an exam room or referred elsewhere.

**Q.** Do I need to do a 2-step PPD test on a new employee that had a negative PPD at her previous workplace?

**A.** See the table below for when to administer 2-step TB skin tests (TSTs).

<table>
<thead>
<tr>
<th>Situation</th>
<th>Recommended Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>No previous TST result</td>
<td>Two-step baseline TST</td>
</tr>
<tr>
<td>Previous negative TST result (documented or not) &gt;12 months before new employment</td>
<td>Two-step baseline TST</td>
</tr>
<tr>
<td>Previous documented negative TST result ≤12 months before new employment</td>
<td>Single TST needed for baseline testing; this test will be second-step</td>
</tr>
<tr>
<td>≥2 previous documented negative TSTs but most recent TST &gt;12 months before new employment</td>
<td>Single TST; two-step testing is not necessary</td>
</tr>
<tr>
<td>Previous documented positive TST result</td>
<td>No TST</td>
</tr>
<tr>
<td>Previous undocumented positive TST result</td>
<td>Two-step baseline TST</td>
</tr>
<tr>
<td>Previous BCG vaccination</td>
<td>Two-step baseline TST</td>
</tr>
</tbody>
</table>

**Q.** Can we bill for the TB skin test we administer to employees?

**A.** The test must be offered at no charge to employees, so if the employee has paid their insurance deductible and the test can be billed to their insurance at no charge to the employee, then that’s acceptable. In any case, use CPT 86580 for the TB skin test and then bill 99211 for the nurse’s interpretation on a later date. Use ICD-9 screening code V74.1 if the test is negative. If the test is positive, use ICD-9 code 795.5, for non-specific reaction to tuberculin skin test without active tuberculosis.

Staff with Staph

**Q.** What are OSHA regulations for employees with open sores who test positive for staph infection?

**A.** Restrict the worker from direct patient care until the infection has been treated for at least 24 hours. You can find advice in writing behind Tab 12 of Quality America’s OSHA Manual: “Suggested Work Restrictions for Employees.”

Logging Chemical Indicators

**Q.** As your Quality America OSHA Manual suggests, we run chemical indicators with each autoclave load and biological indicators once per week. We log our weekly biological indicator results, but not our chemical indicator results. Do we need to log our daily chemical indicator results?

**A.** The chemical indicator test result is physically present on the packets, and the OSHA Manual states that if the chemical indicator shows that the cycle has NOT occurred, you will re-run the cycle for the entire load. For these reasons, we chose not to make (yet another!) log for documenting chemical indicator results.

Time for Titers?

**Q.** We have several employees that have had the hep B vaccine, but it has been several years ago. What is your suggestion on doing titers? I have heard that after so long they are not accurate titers.

**A.** See the table below for when to administer 2-step TB skin tests (TSTs).
TB Skin Testing, Staff with Staph

Storing Vaccines, Eyewash Maintenance

**A.** If the employees you are referring to had titters, then you need not repeat them. CDC says that once an employee shows immunity to HBV, that immunity is lifelong, even if later titters decline. If the employees had the vaccine but not the titer, I recommend performing a titer now, since the bottom line is that you need to know whether or not clinical employees are immune to HBV. If their titer is low, boost them with one dose of HBV and then titer them again.

**Faces, Eyes & Fingers**

**Q.** When performing a finger stick to test hemoglobin, is wearing face or eye protection required?

**A.** No, since a finger stick procedure is not one that can "be reasonably anticipated" to splash or spray a healthcare worker. OSHA cites the "reasonably anticipated" criteria in the Bloodborne Pathogens Standard. If your circumstances are such that splashing COULD occur (kicking children, people using illicit substances, etc.), then you might determine that in these instances, PPE is required.

**PDR Instead of MSDS?**

**Q.** Is it permissible to use the Physicians' Desk Reference (PDR) in place of a Material Safety Data Sheet (MSDS) for a hazardous drug?

**A.** No, because the PDR describes only the drug’s effect on a patient and doesn’t convey hazard information to employees. MSDS contain advice for personal protective equipment, storage requirements, and other emergency-type information such as what to do if the drug leaks or spills from an injectable syringe.

But, the good news is that not all drugs need MSDS. Medications which are in solid, final form for direct administration to the patient (tablets, capsules) are exempt from this requirement, since they couldn’t be reasonably expected to harm employees. Injectables are another story, though. If an injectable is a hazardous chemical, you must have an MSDS.

**Laundry Day at the Surgery Center**

**Q.** Our surgery center does its own laundry. Does OSHA recommend a detergent for laundering scrubs and soiled linens?

**A.** No, OSHA does not recommend a detergent, but references the CDC Guidelines for Laundry in Health Care Facilities concerning water temperatures and bleach:

- Use a detergent in water at least 71º C (160º F) for 25 minutes
- For low temperature (<70 º C) laundry cycles, use chemicals suitable for low-temperature washing, according to manufacturer's instructions
- Use bleach for an extra margin of safety

Remember, handle soiled laundry as little as possible, place it in bags for transporting, use personal protective equipment when sorting, and don’t sort or pre-rinse in patient care areas. For more information, check out CDC’s Guidelines at www.cdc.gov/od/ohs/biosfty/laundry.htm.

**Carrying in Red Bags for Rare Procedures**

**Q.** We are an orthopedic and sports medical center. We keep a biohazardous trashcan in the room where casts are taken off, but we rarely have biohazardous waste in other exam rooms. For these other rooms, may we keep a folded red bag in the cabinet or are we required to have a red bag in an actual trashcan outside of the cabinet?

**A.** You can keep a folded red bag in the cabinet, BUT you need to put it in a trashcan before beginning a procedure where biohazardous waste will be generated. The reason? A healthcare provider can’t be...
holding an item with dripping fluid on it while trying to open a folded biohazard bag. If you can't accurately predict when procedures will be performed that might generate biohazardous waste, then always keep a red bag in a trashcan.

**Storing Vaccines**

**Q.** Are there restrictions on storing vaccines in the door of a refrigerator? We had an incident where one of our drugs (erythropoetin) became unusable when it became too warm on the door of our refrigerator.

**A.** Store vaccines in the middle of the refrigerator or freezer, and NOT on the door. Also, stock and rotate the vaccine supply so that the newest vaccine of each type (with the longest expiration date) is placed behind the vaccine with the shortest expiration date, and use first those that will expire soonest. For more tips on safe vaccine handling and storage, see page 9-26 of Quality America’s OSHA Safety Program Manual.

**Updates on Eyewash Maintenance**

**Q.** When and how should eyewash stations be tested?

**A.** Weekly, remove the protective eyepiece caps, push the handle to the ‘On’ position, and allow the eyewash to run for three minutes. When the time is up, turn off the eyewash, rinse out the eyepiece caps with 10% bleach, flush them with water for 15 seconds, and return them to their original positions. Make sure water pressure is adjusted to provide a gentle flow of water over the eyes – too much pressure can damage the cornea and too little pressure won’t be effective. Four gallons per minute is the minimum effective pressure. For more updates, see page 12.

**Specimens Mixed with Salads?**

**Q.** We are a new facility. I work in the business office. Is it against OSHA rules for us to have a small refrigerator in our office? There is never room in the nurses’ lounge for us to put our lunches.

**A.** It’s fine to have a refrigerator in an office space. Just be sure that nobody puts a blood specimen or a serum-based drug in it – along with your lunch!

**Disposing Tourniquets after Use**

**Q.** I recently hired a phlebotomist from a hospital setting who states that it is an OSHA violation to reuse a tourniquet for phlebotomy. Other than when the patient has a rash, open cuts, or when the tourniquet is contaminated with blood, is it required to discard the tourniquet after each use and use a new one for the next patient?

**A.** This is not an OSHA issue (OSHA is concerned only with employee safety), but an infection control one. From an infection control standpoint, tourniques must be cleaned between patients. This is true of other items that touch patient skin and are reused on other patients, such as stethoscopes. These items could transmit organisms such as MRSA from patient to patient if not disinfected between uses. You can accomplish this by wiping with alcohol or by discarding the tourniquet. On the other hand, if the patient has a rash or an open cut that contacts the tourniquet or if the tourniquet is visibly contaminated with blood, then you need to clean it with something stronger than alcohol, such as a hospital-level disinfectant, OR discard it.

**Nurse Faints and Spills Speculum Bucket**

**Q.** One of our employees fainted and fell onto an open bucket of speculums soaking in green soap. She laid in the spilled soaking solution which saturated her hair and back for about a minute. Is this an exposure incident for bloodborne pathogens?

**A.** The soaking solution is a potentially infectious material, meaning that it should be considered contaminated with...
bloodborne pathogens. With this said, if the nurse had no skin abrasions and the soaking solution did not penetrate her mucous membranes, then this does not constitute a bloodborne exposure and no follow-up blood work needs to be done. Hopefully she removed her clothing carefully (to not touch mucous membranes or abraded skin) and had immediate access to a hot shower! The room should have been cleaned up with a spill kit containing an absorbable material to soak up the contaminated fluid, followed by mopping the floor with hospital-level disinfectant.

Editor’s Note: It’s common practice to leave used speculums soaking in liquid, but the soaking container should be tightly closed when not inserting or removing speculums. If needed, buy stainless steel ones that clamp shut (plastic is porous). If any readers have a good suggestion for where to find such a product, please reply to comments@quality-america.com.

**OSHA Manual UPDATES**

**New Eyewash Maintenance Instructions:**

- Medical and Dental OSHA Safety Program Manual owners can download instructions by going to:
  - www.quality-america.com/resource-center/safety_manual_updates/OSPMU03.01.06.htm

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