Docket No. OSHA-2025-0006
Occupational Safety and Health Administration (OSHA)
Supplemental Comment of Kelly Taylor and Alan R. Johnston on Amending the Medical Evaluation Requirements in the Respiratory Protection Standard for Certain Types of Respirators

We submit this supplemental comment after reviewing the OSHA materials and transcripts of the March 31 and April 1, 2026 meetings of the Advisory Committee on Construction Safety and Health (ACCSH), during which ACCSH considered OSHA's proposal to remove medical evaluation requirements for certain respirators. Because OSHA's March 31 oral presentation substantially reiterated the rationales set out in its ACCSH slides, the discussion below refers primarily to the slide statements. Those references should be understood to include the same or substantially similar points made verbally by OSHA representatives during the March 31 presentation.[1]

Taylor's original comment did not oppose OSHA's proposal to remove medical evaluation requirements for loose-fitting powered air-purifying respirators (PAPRs). This supplemental comment focuses on filtering facepiece respirators (FFRs). OSHA should not finalize the proposed exemption from medical evaluation requirements for required FFR use. OSHA should sever FFRs from loose-fitting PAPRs and retain the existing medical evaluation requirement for FFRs when their use is required.[2]

In the Occupational Safety and Health Act of 1970 (the OSH Act), Congress declared the purpose and policy of the Act: "[t]o assure safe and healthful working conditions for working men and women; by authorizing enforcement of the standards developed under the Act; by assisting and encouraging the States in their efforts to assure safe and healthful working conditions; by providing for research, information, education, and training in the field of occupational safety and health;". Section 2(b)(7) further states, "by providing medical criteria which will assure insofar as practicable that no employee will suffer diminished health, functional capacity, or life expectancy as a result of his work experience;". The existing respirator medical evaluation requirement is an example of the medical criteria Congress intended OSHA to use to protect workers from diminished health, reduced functional capacity, or shortened life expectancy caused by work.[3]

OSHA states in its ACCSH slides that the proposed change would affect filtering facepiece respirators, using N95 "dust masks" as the example. That framing is too narrow. FFRs are not limited to N95 respirators. NIOSH identifies nine FFR filter classes: N95, N99, N100, R95, R99, R100, P95, P99, and P100. OSHA's own respiratory protection guidance likewise explains that particulate filters are labeled with an N, R, or P and an efficiency number of 95, 99, or 100. OSHA should not equate the entire FFR category with brief N95 "dust mask" use.[4]

OSHA's analysis should account for the fact that FFRs are not a single device or use case. P100 FFRs, for example, have higher filter efficiency than N95 FFRs and typically produce higher flow resistance (Zhu et al., 2020). OSHA's statement that available data indicate "minimal" physiological effects is therefore incomplete as applied to required FFR use as a category. As established in Taylor's original comment, available studies typically involve healthy individuals under controlled conditions. The required medical

[1] OSHA ACCSH Meeting Transcript, Mar. 31, 2026; OSHA ACCSH Rulemaking Briefing Presentation, Docket No. OSHA-2025-0001.
[2] Taylor, Comment on Docket No. OSHA-2025-0006; OSHA Proposed Rule, 90 Fed. Reg. 28463, July 1, 2025.
[3] Occupational Safety and Health Act of 1970, Pub. L. 91-596, § 2(b), 84 Stat. 1590, codified at 29 U.S.C. § 651(b).
[4] OSHA ACCSH Rulemaking Briefing Presentation; NIOSH, Filtering Facepiece Respirators; OSHA, Respiratory Protection eTool, Particulate Filters.

evaluations, however, are intended to screen workers who may have medical symptoms or conditions that could be exacerbated by FFR use, resulting in diminished health, functional capacity, or life expectancy. What may be described as minimal physiological effect in a healthy study population may be significant for a medically compromised worker, particularly during prolonged use or moderate to heavy work effort.[5]

OSHA's proposed amendment appears internally inconsistent. OSHA's ACCSH slides state that the proposed exemption would not apply to tight-fitting PAPRs, meaning tight-fitting PAPRs would remain subject to medical evaluation requirements. Yet the proposal would exempt FFRs, even though FFRs are also tight-fitting respirators, require a face seal, and rely entirely on the wearer's own respiratory effort to draw air through filter media. OSHA has not adequately explained why medical evaluations remain appropriate for tight-fitting PAPRs but would no longer be required for tight-fitting FFRs that operate by negative pressure.[6]

According to the March 31 and April 1, 2026 ACCSH transcripts, several Committee members discussed field experience and anecdotal examples concerning employees' use of respirators, including required N95 use for short-duration tasks. Some members also expressed concern that medical evaluation requirements may deter or complicate the use of respirators for brief tasks when respiratory protection is required. Those concerns may be relevant to some short-duration scenarios, but they do not justify removing medical evaluation requirements for all required FFR use. OSHA's proposed exemption is not limited to brief tasks, voluntary use, or N95 "dust mask" use. It would apply broadly to required use of FFRs as a category.[7]

In Taylor's role as CEO of Damarco Solutions, LLC, she has access to data from the Respexam system, an online respirator medical screening system that uses Federal OSHA's Appendix C questionnaire as the baseline for an expanded online questionnaire. Respexam assists employers in screening employees for conditions that may place them at risk while wearing a respirator. For this supplemental comment, Damarco Solutions, LLC reviewed evaluations completed from January 1, 2023 through December 31, 2024, the same date range as Taylor's original comment.

Because the Respexam system allows employers to screen employees for multiple respirator types at one time, Damarco Solutions, LLC limited this review to evaluations involving FFRs only to better understand expected duration and work effort. In the dataset, 76.3% of FFR-only evaluations involved expected respirator use of two or more hours per day. More specifically, 71.1% involved expected respirator use of more than four hours per day. Of those evaluated for more than four hours of use per day, 83.3% involved medium, heavy, or very heavy work effort.[8]

These data do not support treating required FFR use as primarily brief or incidental. OSHA should not rely on short-duration or anecdotal examples to justify eliminating medical evaluation requirements for workers who must use FFRs to protect against exposure to workplace hazards.

Taylor's original comment provided an analysis of Respexam data showing that medical screening identifies a meaningful subset of FFR users who require restriction or are unable to wear an FFR. Among referred FFR users for whom follow-up was received, 15.4% were restricted in FFR use and 11.6% were determined

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[5] Taylor, Comment on Docket No. OSHA-2025-0006, discussion of studies involving healthy individuals under controlled conditions.

[6] OSHA ACCSH Rulemaking Briefing Presentation; OSHA Proposed Rule, 90 Fed. Reg. 28463, proposed revision to 29 C.F.R. § 1910.134(e)(1)(ii).

[7] OSHA ACCSH Meeting Transcript, Mar. 31, 2026; OSHA ACCSH Meeting Transcript, Apr. 1, 2026.

[8] Respexam is an online respirator medical screening system operated by Damarco Solutions, LLC in partnership with 3M. Review of de-identified Respexam FFR-only evaluation records completed Jan. 1, 2023 through Dec. 31, 2024, conducted by Damarco Solutions, LLC.

unable to wear an FFR. Of those restricted, 67.9% had been referred for pulmonary or cardiac symptoms. Of those determined unable to wear an FFR, 65% had been referred for pulmonary or cardiac symptoms.[9]

OSHA's ACCSH slides state that "very few workers (around 1-2%) are denied respirator use based on the results of a medical evaluation," and suggest that this means the screening process has limited impact on preventing at-risk individuals from using respirators. Even accepting OSHA's 1 to 2 percent figure, applying that percentage to OSHA's own estimate of approximately 2.6 million FFR users would represent approximately 26,000 to 52,000 affected FFR users who may be medically unable to wear an FFR.[10] That estimate does not include workers who are cleared with restrictions or limitations. OSHA should not characterize the medical evaluation process as having limited impact without addressing the individual workers represented by its own percentages, or the additional workers whose safe use depends on restrictions identified through medical evaluation.

Additionally, a low denial or disqualification rate does not show that medical evaluations lack value. It shows that questionnaire-based screening clears most workers efficiently while identifying the group that needs further evaluation, restriction, or disqualification in order to protect workers whose medical conditions may make required respirator use unsafe.

OSHA states in its ACCSH slides that, under the current standard, "there is a requirement for every worker to visit a PHLCP [sic] to complete a questionnaire and obtain clearance before they can wear an N95 for a required task." That statement mischaracterizes the existing standard.

The current standard does not require every worker to visit a PLHCP. Section 1910.134(e)(2)(i) provides that the employer must identify a physician or other licensed health care professional to perform medical evaluations "using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire." Section 1910.134(e)(2)(ii) further provides that the medical evaluation must obtain the information requested in Sections 1 and 2, Part A of Appendix C.[11]

In practice, an employer may have the employee complete the required questionnaire and submit it for PLHCP review to determine whether any follow-up is needed. Employers may use in-house medical staff, contract with local PLHCPs, or use online medical screening services such as Respexam and similar providers. OSHA's characterization overstates the burden imposed by the current medical evaluation requirement.

OSHA states in its ACCSH slides that "FFRs and PAPRs are not permitted for use in immediately dangerous to life or health (IDLH) environments" and that, "[i]f an employee experiences discomfort or symptoms, they can safely remove the respirator." That rationale is incomplete.

Required use means the respirator is necessary to protect the employee from a recognized workplace hazard. If an employee removes a required respirator without first leaving the hazardous area, the employee may be exposed to the hazard the respirator was selected to control. Although that hazard may not be immediately dangerous to life or health, it may still contribute to diminished health, reduced functional capacity, or shortened life expectancy as a result of work exposure. OSHA should not assume

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[9] Taylor, Comment on Docket No. OSHA-2025-0006, analysis of Respexam outcomes for referred FFR users.
[10] OSHA ACCSH Rulemaking Briefing Presentation, Docket No. OSHA-2025-0001; OSHA, *Amending the Medical Evaluation Requirements in the Respiratory Protection Standard for Certain Types of Respirators*, Proposed Rule, 90 Fed. Reg. 28463, July 1, 2025.
[11] 29 C.F.R. § 1910.134(e)(2)(i)-(ii); 29 C.F.R. pt. 1910, subpt. I, app. C.

that every worker experiencing symptoms while wearing an FFR will be able to leave the hazardous area before removing the respirator.

In addition, IDLH status is not a meaningful basis for exempting FFRs from medical evaluation. Other respirator types that are not appropriate for IDLH environments would remain subject to medical evaluation under OSHA's proposed amendment. OSHA therefore should not rely on non-IDLH use as a differentiating rationale for removing medical evaluation requirements for required FFR use.

OSHA also states in its ACCSH slides that, "[d]espite the significant increase in the use of FFRs and PAPRs during the COVID-19 pandemic, often without prior medical evaluation, OSHA is not aware of any data indicating an increase in adverse health outcomes for individuals with underlying medical conditions." That statement does not provide a sufficient basis for removing medical evaluations unless OSHA identifies a reliable mechanism by which such outcomes would have been captured, attributed to respirator use, and reported to OSHA. The absence of data known to OSHA is not evidence that adverse outcomes did not occur. At most, it reflects a lack of available surveillance data and does not establish that medical evaluations are unnecessary for required FFR use.

OSHA's ACCSH slides identify annualized cost savings, reduced labor hours, and fewer follow-up medical examinations as benefits of the proposed amendment. Those projected savings should not be treated as net benefits without considering the function of the medical evaluation requirement and the assumptions underlying OSHA's analysis.[12]

The current standard permits questionnaire-based medical evaluation and does not require every worker to physically visit a PLHCP before required respirator use. Therefore, OSHA should not evaluate the burden of the current standard as though each medical evaluation requires an in-person examination.

Taylor's original comment provided an analysis of Respexam screening outcomes showing an FFR/PAPR-only referral rate of 3.5%, substantially lower than OSHA's assumed follow-up rate of 23%. OSHA's projected savings from avoided follow-up medical examinations are therefore significantly overstated.[13]

Additionally, eliminating medical evaluations does not eliminate medical risk. If workers who would have been restricted or determined unable to wear an FFR after medical evaluation are instead required to use one, costs may be shifted downstream through workers' compensation claims, lost time, restricted duty, replacement labor, and higher experience-rated premiums. OSHA should not count avoided screening costs as net savings without considering whether those costs are merely transferred to workers, employers, insurers, or the workers' compensation system after an adverse event occurs.

The Committee also discussed AGC's proposal that OSHA provide best-practices guidance rather than continue the established medical evaluation requirement. Best-practice guidance may be useful where employers are addressing voluntary respirator use or short-duration situations where respirator use is not required. However, when an employer requires an employee to wear an FFR to protect against a workplace exposure, guidance does not determine whether that individual worker can safely wear the respirator. The OSH Act specifically recognizes the role of medical criteria in preventing diminished health, reduced functional capacity, or shortened life expectancy resulting from an employee's work experience. The

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[12] OSHA ACCSH Rulemaking Briefing Presentation, Docket No. OSHA-2025-0001; OSHA, *Amending the Medical Evaluation Requirements in the Respiratory Protection Standard for Certain Types of Respirators*, Proposed Rule, 90 Fed. Reg. 28463, July 1, 2025.

[13] Taylor, Comment on Docket No. OSHA-2025-0006, analysis of Respexam screening outcomes; OSHA, *Amending the Medical Evaluation Requirements in the Respiratory Protection Standard for Certain Types of Respirators*, Proposed Rule, 90 Fed. Reg. 28463, July 1, 2025.

current medical evaluation requirement performs that screening function. A nonmandatory best-practices document may supplement the standard, but OSHA should not consider guidance an appropriate substitute for the medical evaluation requirement.[14]

Lastly, the ACCSH discussion raised a practical concern that OSHA should take seriously: creating exceptions from medical evaluation requirements for some respirator types may create confusion for employers. In our experience, employers often conflate medical evaluation requirements with fit-testing requirements. Adding further exceptions to the existing long-standing standard risks making employers' respiratory protection obligations less clear, particularly where fit testing and other program requirements would continue to apply even if medical evaluations were removed for some respirator types.[15]

In summary, the record does not support removing medical evaluations for required FFR use. OSHA has not shown that brief N95 use is representative of all required FFR use. OSHA has not shown that workers expected to wear FFRs for multiple hours per day during medium or heavier work can safely be excluded from medical evaluation. And OSHA has not shown that the low percentage of workers restricted or disqualified means the screening process lacks value.

For these reasons, OSHA should not finalize the proposed exemption for required use of filtering facepiece respirators. If OSHA proceeds with any portion of the proposal, it should sever loose-fitting PAPRs from FFRs and retain the existing medical evaluation requirement for required FFR use.

Respectfully,

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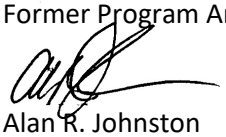

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June 16, 2026

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[14] OSHA ACCSH Meeting Transcript, Apr. 1, 2026; Occupational Safety and Health Act of 1970, Pub. L. 91-596, § 2(b), codified at 29 U.S.C. § 651(b).

[15] OSHA ACCSH Meeting Transcript, Mar. 31, 2026; Taylor, Comment on Docket No. OSHA-2025-0006, discussion of employer confusion between medical evaluation and fit-testing requirements.