OSHProterie

January 15, 2026

Department of Industrial Relations
California Occupational Safety and Health Standards Board
2520 Venture Oaks Way, Suite 350
Sacramento, CA 95833

Submitted: oshsbrulemaking@dir.ca.gov

RE: Title 8 §1512 Emergency Medical Services and §3400 Medical Services in First Aid Proposed Rulemaking – Written Comments

To the California Occupational Safety and Health Standards Board Members and Staff:

Please accept the OSH Proterie's comments on the California Occupational Safety and Health Standards Board's (OSHSB or Board) proposed rulemaking on Title 8 §1512 Emergency Medical Services in the Construction Safety Orders and §3400, Medical Services and First Aid in the General Industry Safety Orders (Proposed Text[1]), noticed on November 28, 2025[2] (Notice).

The OSH Proterie is a network of Occupational Safety and Health (OSH) compliance leaders across industries. Our members are directly responsible for workplace environmental safety and health, and we provide their collective voice to OSH agencies to improve safety, compliance, and operational effectiveness.

I. General Comments

We appreciate and support the Board's efforts to improve safety by modernizing the California Division of Occupational Safety and Health's (CalOSHA) first-aid requirements and simplifying compliance by allowing employers two clear options: (1) purchase or align with the ANSI/ISEA Z308.1-2021 (ANSI kit), or (2) rely on approval by a physician or other licensed health care professional (PLHCP).

One of the benefits of retaining the PLHCP option is that employers already in compliance under the current standards should not need to replace existing kits, as current requirements already mandate physician approval.

[1] Proposed Text: https://www.dir.ca.gov/oshsb/documents/First-Aid-2025-SAR-Text-Nov2025.pdf
[2] Notice of Proposed Rulemaking, Emergency Medical Services and First Aid: https://www.dir.ca.gov/oshsb/documents/First-Aid-2025-Notice-Jan2026.pdf

However, as drafted, the proposal introduces new elements that eliminate much of this flexibility and create ambiguity in enforcement. What began as a simple update—modernizing kit contents—has become unnecessarily over-engineered and, we believe, the impact and particularly the economic analysis has been downplayed.

To clarify and alleviate our concerns, we recommend specific changes to the proposed text and request the Board issue a 15-Day Notice of Modifications.

Furthermore, we believe the Board has fundamentally underestimated the economic impact of this proposal. As detailed in Section V, real-world data from our members shows that the Board's assumptions for kit maintenance are off by a factor of nearly 20-to-1. When these corrected material costs are combined with a conservative estimate of the labor required for new mandatory assessments and weekly inspections, **the statewide cost easily exceeds the $50 million threshold, necessitating a Standardized Regulatory Impact Assessment (SRIA) which has not been conducted.**

II. "Ready Access" and Misapplication of Federal OSHA Interpretation

Listed as an objective of the revisions in the Notice[3] and Initial Statement of Reasons (ISOR)[4] is the **new requirement for *all employees* to be able to access a first aid kit within three-four (3-4) minutes** (i.e., "ready access"). The Board explains and justifies this requirement by citing Federal OSHA's interpretation of "near proximity," which is 3–4 minutes, relying on a January 16, 2007, OSHA Letter of Interpretation (LOI)[5]:

> *"This change is necessary to ensure that the proposed changes to section 1512 [3400] are consistent with federal OSHA's 2007 interpretation of 'near proximity' for first-aid kits, which states that, 'while the standards do not prescribe a number of minutes, OSHA has long interpreted the term "near proximity" to mean that "emergency care must be available within no more than 3-4 minutes from the workplace..."'"*

This interpretation is misapplied and is a fundamental mischaracterization.

The January 16, 2007[6] LOI *addresses the availability of emergency medical services and the requirement to have employees trained in first aid*, at the worksite, as required in §1910.151(b)[7] and

[3] Notice Objective (3) page 2.
[4] ISOR Objective (3), page 1: https://www.dir.ca.gov/oshsb/documents/First-Aid-2025-ISOR-Nov2025.pdf
[5] ISOR pages 6, 12.
[6] Federal OSHA January 16, 2007 LOI: https://www.osha.gov/laws-regs/standardinterpretations/2007-01-16-0
[7] 29 CFR §1910.151(b): https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.151

§1926.50(c)[8], **not** the physical location or availability of first-aid kits. Federal OSHA clearly distinguishes between:

- **"Near proximity" and "reasonably accessible"** (applies to EMS/trained personnel availability)
- **"Readily available"** (applies to first-aid supplies).

We recommend reading the LOI in full, but provide the following excerpts to explain the mischaracterization:

> *"The primary requirement addressed by these standards is that an employer must ensure prompt first aid treatment for injured employees, either by providing for the availability of a trained first aid provider at the worksite, or by ensuring that emergency treatment services are within reasonable proximity of the worksite..."*
>
> *"...One option these standards provide employers is to ensure that a member of the workforce has been trained in first aid..."*
>
> *"...The other option for employers is to rely upon the reasonable proximity of an infirmary, clinic or hospital..."*

Additional guidance in the LOI, and in a March 23, 2007[9] LOI, not included in the Board's explanation, is that while 3-4 minute access to EMS is required for workplaces where serious accidents are possible (e.g., falls, electrocution, amputation):

> *"OSHA acknowledges that in some low-hazard workplaces, such as office settings, a response time of up to 15 minutes may be reasonable."*

The Board should also acknowledge an LOI from April 18, 2002[10] requesting interpretation of first aid supplies being "readily available." Federal OSHA is unable to provide a time-specific answer but does address the question in relation to the *person providing the first-aid treatment*, not an employee accessing a first-aid kit:

> *"The term "readily available" is not defined in the standard. However, responding in a timely manner can mean the difference between life and death. Therefore, the person who has been trained to render first aid must be able to quickly access the first aid supplies in order to effectively provide injured or ill employees with first aid attention. The first aid supplies should be located in an easily accessible area, and the first aid provider generally should not have to travel through several doorways, hallways and/or stairways to access first aid supplies."*

[8] 29 CFR §1926.50(c): https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.50
[9] Federal OSHA March 23, 2007 LOI: https://www.osha.gov/laws-regs/standardinterpretations/2007-03-23
[10] Federal OSHA April 18, 2002 LOI: https://www.osha.gov/laws-regs/standardinterpretations/2002-04-18-0

When asked if "near proximity" can be used to determine the location of first aid kits, Federal OSHA indirectly says no by referring to the January 16, 2007, LOI (which is specific to location of EMS).

The Board's justification for this time metric is not only inaccurate, but also not risk-based. Maintaining this expectation will have significant impact and trigger additional first-aid kits across the State—not accounted for in the economic analysis. For example, requiring every employee to be within 3-4 minutes of a first-aid kit implies that **every company car, and potentially personal car that is authorized for use by the employer, will require a first-aid kit to be installed and maintained**. It will result in time-based compliance checks and citations. This is not only unnecessary, but unreasonable and we do not believe is the intent of Federal OSHA or the Board.

Recommendation:

We urge the Board to correct the rulemaking record and withdraw the expectation that every employee needs to be within 3-4 minutes of a first-aid kit. Absent clarification, employers may face citations based on a faulty premise that is inconsistent with Federal OSHA's guidance.

III. Mandatory Appendix A – First Aid Guide

The new mandatory Appendix A lists specific topics that must be included in the First Aid Guide. While we understand why the contents must be specified in the regulatory text, this requirement eliminates flexibility for employers relying on PLHCP-approved kits.

As drafted:

- Employers with physician-approved kits, not labeled ANSI approved, will need to review every existing guide.
- If current guides do not exactly match Appendix A, employers must create or purchase and install new guides.
- At a minimum, every employer in the state must conduct an audit of existing kits.
- **This is an automatic, statewide operational requirement that is not acknowledged in the economic analysis.**

Additionally, Appendix A reads more like a first-aid training curriculum than a simple reference guide. It includes topics such as AED use, CPR, assessing the injured person, and recognizing signs and symptoms of shock. We do not oppose these topics being available for reference and admit that many first-aid guides already include similar content. Our concern is that listing these topics in

regulatory text raises a legitimate question: will there be an expectation that employees who have access to these guides will need to understand and be trained[11] on these procedures?

Recommendations: To provide the intended flexibility of the PLHCP and needed clarity, we recommend the following:

1. Allow a PLHCP to approve the First Aid Guide, consistent with approval of kit contents.

   §1512 and §3400, Table 1: Minimum Requirements for First-Aid Kits:

   "Topics included in the first-aid guide shall consist of those listed in Appendix A of this section, which complies with Appendix A in ANSI/ISEA Z308.1-2021, **or be determined by an employer-authorized physician or other licensed healthcare professional (PLHCP), as defined in section 5144.**"

2. Clarify that Appendix A does not require certification or training for all employees by adding an asterisk (*) to the list:

   REQUIRED CONTENTS OF THE FIRST-AID-GUIDE (ANSI/ISEA Z308.1-2021) *
   "***Employees are not required to be trained on the contents of this guide.**"

IV. Additional Kits and Supplies

The added language in §1512(c)(2) and §3400(c)(3) requires employers to provide additional kits, quantities, and types of first-aid supplies based on workplace size, employee location(s), and hazards.

We support the purpose of requiring employers to provide first-aid supplies *to address unique, known or anticipated workplace hazards*[12]. However, we are concerned the proposed language unnecessarily expands the scope and requirement for additional supplies and kits; the Board's statements in the ISOR supports this concern.

The requirement, in new subsections §1512(c)(2) and §3400(c)(3), is **positioned after, and in addition to**, the "minimum" requirements established by Table 1 or a PLHCP. As explained in the ISOR[13], this means that even kits approved by a PLHCP may be deemed insufficient unless further assessed and supplemented:

[11] Certified First Aid training is 4 hours; Certified AED training is 4 hours.
[12] ISOR Objective 4, page 1; bulleted reasoning on pages 9 and 11.
[13] ISOR pages 9 and 11.

> *"These subsections ensure that, beyond the minimum list of first-aid supplies required under Table 1 (or as recommended by a PLHCP),* ***any additional first aid supplies that may be needed to address unique hazards in the workplace be provided by the employer****." [emphasis added]*

The ISOR further clarifies that this responsibility "rests with the employer."[14] We support that this requirement no longer rests solely with a physician, but the new text eliminates the flexibility for an employer to utilize the expertise of a PLHCP for unique hazards. The proposal also removes language that clarifies additional supplies should be based on anticipated and known hazards:

> §1512(2) "...~~based upon the anticipated incidence and nature of injuries and illnesses~~..."

Our concern is further confirmed by the example in the ISOR[15], that explains employers will be required to assess heat exposure and provide supplies to cool and hydrate employees while waiting for EMS:

> *"Where employees could be exposed to high heat, the employer would be required to assess the potential frequency, intensity and duration of exposure to high heat and provide first aid items that could be used to cool and hydrate a heat-stressed employee while emergency medical services are being summoned."*

This expectation and level of detailed assessment is not apparent from the proposed text and would not be reasonably understood by employers reading the regulation. The Board's example illustrates this - CalOSHA's heat illness prevention standards apply to all industries, and it is our understanding that CalOSHA does not consider heat a unique workplace hazard. It is also important to note that CalOSHA's indoor and outdoor heat illness prevention standards, §3395 and §3396(f)(1), already address employer responsibilities for responding to signs and symptoms of heat illness, including first-aid measures. This is in addition to the water, rest, shade requirements and the newly required cold packs in the ANSI kit. The ISOR example is therefore unnecessary and raises concerns about how CalOSHA enforcement will apply the new first-aid requirements.

Recommendations:

To preserve flexibility while ensuring unique hazards are addressed, we recommend revising §1512(c)(2) and §3400(c)(3) as follows:

1. "Based upon its size, the location(s) of employees, and the types of **unique** hazards in the workplace, the employer, **or an employer-authorized physician or other licensed healthcare professional (PLHCP), as defined in section 5144,** shall evaluate the need for, ~~**and provide,**~~ additional first-aid kits and additional types and quantities of first-aid

[14] ISOR page 8.
[15] ISOR pages 11 and 13.

equipment and supplies. **based upon the anticipated incidence and nature of unique hazards in the workplace.**"

2. "**Employers shall provide additional first aid kits, and additional types and quantities of first-aid equipment and supplies based upon the anticipated incidence and nature of unique hazards in the workplace**."

V. Deficiencies in the Economic Impact Analysis

The Board's estimated cost of **$15.4 million[16] in the first year** relies on a generalized 50% "overage" to account for all labor and administrative burdens[17]. This is less than **$9 per construction company** and less than **$10 per general industry business**[18]. These figures are fundamentally flawed when compared to actual operational data.

1. Underestimated Replacement Costs:

The Board estimates that only 10 sets of items will be used from each kit annually (e.g., one box of bandages, one cold pack), with an estimated replacement cost of $1.20 per item, **$12.00 per kit[19].**

In contrast, data from an OSH Proterie member with 14 kits shows an actual monthly replacement cost of **$315.36**. This includes:

- 9 boxes of 1x3 in. bandages ($7.65/box)
- 7 boxes of antibiotic packets ($5.45/box)
- 7 boxes of antiseptic wipes ($2.07/box)

At this rate, the annual cost for this single employer is **$3,784.32**, or approximately **$270 per kit, per year**. The Board's estimate of $12.00 is not just conservative; it is untethered from the reality of maintaining a compliant workplace.

2. "Ready Access" Gap:

The requirement to access a kit within 3-4 minutes will necessitate additional kits. The economic analysis admits this is a "facility-by-facility" assessment and that additional kits may be required when employees are not co-located or are in large facilities[20].

Despite this, the Board fails to quantify the number of additional kits required statewide. The analysis only addresses the $25.00 cost of a kit for the 57% of businesses who must replace or

[16] ISOR page 20.
[17] ISOR pages 16 and 19.
[18] ISOR page 21.
[19] ISOR page 21.
[20] ISOR page 17.

update existing supplies.[21] By failing to model the proliferation of kits required to meet the "3-4 minute" benchmark—including kits for company vehicles and large facilities—the Board has ignored a primary cost driver of the rulemaking.

3. Construction Checks Before Each Job / Weekly: Time to conduct checks is either not considered or grouped with the 50% overage. We estimate a 5-minute weekly check at $60/hr is $258/year—apply this to the Board's number of affected businesses in construction[22]:
89,489 x $258 = *$23,088,162.*

4. Hazard Assessments: $0.00 is quantified for the professional time to evaluate "frequency, intensity, and duration" of hazards and additional supplies, as required.

5. Additional Supplies: There is no individual estimate or analysis of the cost of supplies resulting from new hazard assessments.

6. Mandatory Appendix A: Checking and replacing First Aid Manuals does not seem to be considered.

7. SRIA Threshold: If a modest 10 hours of total annual labor per construction employer is applied, the statewide cost jumps by over $50M, immediately triggering a Standardized Regulatory Impact Assessment (SRIA): ***10 labor hours x $60/hour x 89,489 = $53,693,400***

In addition to the current requirement to conduct periodic checks, we acknowledge there will be cost savings from removing the physician requirement for *new businesses* and the portable oxygen bottle in construction. We also understand that individual employer models are not always directly comparable to statewide estimates. However, **using common sense, this economic analysis is fundamentally flawed and grossly underestimated.**

VI. Conclusion

We fully support modernizing first-aid kit contents and simplifying compliance for employers. Our members already maintain robust first-aid kits and supplies to address unique workplace hazards; these protections are effective, and the status quo is working. To that end, this rulemaking *should* have little impact.

In reality, that may end up being true—but as drafted, the proposal goes beyond the original objective and introduces unnecessary new requirements, enforcement ambiguity, and underestimated costs. This is not acceptable, and these issues cannot be ignored or overlooked.

[21] ISOR page 19.
[22] ISOR page 21.

We believe our recommended changes preserve the Board's intent while ensuring the regulation is workable, enforceable, and aligned with real-world implementation. We urge the Board to revise the proposal with these necessary changes and issue a 15-Day Notice of Modifications.

Thank you for the opportunity to provide comments. We remain committed and available to support this process and rulemaking.

Sincerely,

Helen Cleary
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