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March 6, 2020

The Honorable Eugene Scalia
Secretary of Labor
United States Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

***RE: To Address the Outbreak of COVID-19: A Petition for an OSHA
Emergency Temporary Standard for Infectious Disease***

Dear Secretary Scalia:

The world is on the verge of a deadly coronavirus pandemic due to COVID-19 and the disease is now spreading quickly through the United States. The impact of the outbreak has already been far reaching and the threat is growing. Current estimates demonstrate that over 19 million workers in the United States would be at elevated risk of exposure to coronavirus in the event of a widespread outbreak, a significant portion of whom could become infected and die. These are the workers who answer the call when an outbreak occurs and they deserve to have confidence that the appropriate resources, equipment, training and protocols are readily available in their workplaces to protect themselves, as well as to avoid infecting other people, including patients, co-workers, the public, and their families when they go home. OSHA has the obligation to ensure the health and safety of all working people, particularly from an infectious disease such as this coronavirus.

Given the significant and growing threat that health care workers, first responders, airline and other transportation workers, social service, and other public-facing workers are now facing from the COVID-19 outbreak, and the immediate need for workplaces to plan, prepare and respond to this threat, the undersigned labor organizations, representing millions of working people, hereby petition the Occupational Safety and Health Administration to issue an Emergency Temporary Standard to protect working people from occupational exposure to infectious diseases, including COVID-19.

Millions of working people in the United States are at risk of facing a deadly coronavirus pandemic.

The novel coronavirus, SARS-CoV-2 that is the source of the COVID-19 outbreak, evolved in Wuhan, Hubei Province, China and the outbreak has spread to 79 countries throughout every continent except for Antarctica. The World Health Organization (WHO) declared a global health emergency on January 30, 2020 and raised the global level risk assessment to “very high” on February 28, 2020, the highest designation. Currently, on the date of this petition, the WHO has reported 95,270 confirmed cases and 3,280 deaths globally, including many health care workers infected in China. Within the United States, the Centers for Disease Control and Prevention (CDC) reports 99 confirmed cases, including at least 20 cases of community transmission, and 10 fatalities. In the current outbreaks near Sacramento and Seattle, more than 200 nurses, other health care workers and public safety workers are undergoing 14-day precautionary medical removal because their employers did not prevent their possible exposure to the coronavirus. These vital workers are sidelined from providing much needed care and face risk of developing the disease. Employers following an OSHA Infectious Disease Standard would have planned for and prevented their exposure. We need our healthcare and public safety workers on the job now and in the coming months ahead. Community transmission in the United States is evidence that the deadly virus is spreading and circulating throughout the country. Infectious disease experts have estimated that a pandemic could kill tens of millions of people worldwide.ⁱ

COVID-19 is a rapidly evolving outbreak and there are still many unknowns about the transmission, infectivity, and severity. However, the rapid spread, confirmed cases and fatalities show that this strain is highly infectious, easily transmissible, and virulent. Also, as with other coronaviruses, infection can cause mild symptoms, including a runny nose, sore throat, cough, and fever. It can also be more severe for some, resulting in pneumonia, difficulty breathing, or death. Older people and people with pre-existing medical conditions appear to be more vulnerable to becoming severely ill with the virus. Yet, any infected individual is at risk of more severe symptoms and may require medical attention.

There is a chilling yet realistic possibility of a coronavirus pandemic and the potential for a catastrophic toll in mortality and morbidity cannot be taken lightly. The following are key assumptions underlying the risk of a pandemic:

- Susceptibility to this pandemic coronavirus will be universal as there is no pre-existing immunity to this novel virus among humans.
- There is evidence of sustained human-to-human transmission.ⁱⁱ Early studies have estimated that each disease’s reproductive number, or the number of people a single infected person is likely to infect, is over two.^{iii, iv}
- Some persons will become infected but not develop clinically significant symptoms. There is concern that the severity of illness is not correlated to the ability to transmit the virus.^v

- The virulence of the virus is not fully understood, but the case-fatality rate is estimated to be less than 3%.^{vi}
- There is evidence of multiple routes of infection, including respiratory, fecal-oral and bodily fluids.^{vii}
- A virus that transmits efficiently, with a lower pathogenicity, can create a large-scale spread.^{viii}

The global outbreak is expanding, resulting in several countries implementing significant public health protocols, including citywide lockdowns.^{ix}

The workers at the forefront of exposure to this growing outbreak include health care workers, fire fighters, law enforcement officers, emergency medical service workers, pilots and flight attendants, other transportation workers, and other public service workers including those with broad exposure to the public who may be identified as “essential personnel” by employers during an outbreak. Table 1 shows an estimate of employment in the most at-risk industries. However, additional workers are at risk, such as those performing tasks such as a construction worker in a hospital or a utility worker dealing with potentially contaminated wastewater. In addition, any worker who interacts with the public frequently is at an increased risk of exposure, such as a hotel housekeeper, retail worker, teacher, customer service worker or food service worker. Workers who enter people’s homes, such as home health aides, telecommunications technicians, and other service providers will be at increased risk with a worsening outbreak as more people are quarantined or ill at home. The evidence of this risk outside of healthcare has been seen in other countries with infected individuals, including taxi drivers, cashiers and bus drivers, and the danger of transmission in crowded workplaces is evidenced by the cruise ship outbreak where passengers and crew were quarantined and the long-term elder care facility in Washington state where residents have died and health care workers have been hospitalized.

Table 1: Average Annual Employment Numbers by Selected High-risk Industries, 2018.

Industry	Average Annual Employment (2018)
Air transportation (private)	502,815
Water transportation (private)	64,463
Transit and ground passenger transportation (private)	479,974
Scenic and sightseeing transportation (private)	33,999
Support activities for transportation (private)	709,766
Ambulatory health care services (private)	7,477,842

Industry	Average Annual Employment (2018)
Hospitals (private)	5,061,617
Nursing and residential care facilities (private)	3,344,908
Social assistance (private)	3,857,060
Death care (private)	136,250
Medical and diagnostic laboratories (private)	275,417
Police protection (government)	544,417
Correctional units (government)	496,776
Fire protection (government)	208,189
TOTAL	19,336,433

Source: U.S. Bureau of Labor Statistics. Quarterly Census of Employment and Wages, 2020.

The current government recommendations to protect workers fall short.

At the beginning of the outbreak, even before WHO officially declared a global public health emergency, the United States government, recognizing the significance of the outbreak, took action. Voluntary guidance to protect some workers has been issued by the CDC, National Institute for Occupational Safety and Health (NIOSH), and Occupational Safety and Health Administration (OSHA).

However, even when OSHA has identified an occupation at high-risk of exposure to COVID-19, OSHA has not issued detailed recommendations. For example, with airline workers, OSHA references a CDC website with recommendations for the airline industry and the CDC does not provide as clear or specific of guidelines as OSHA has provided for different groups of workers. For example, CDC recommends using protective equipment from the Universal Precaution Kit when tending to a sick traveler—a kit that does not include a N95 respirator. To remedy this problem, clear, effective requirements and recommendations issued by one authoritative agency is required—OSHA.

The OSHA guidance for COVID-19 includes essential elements that must be codified in an ETS for infectious diseases.

- Acknowledging a range of workers who are at an elevated risk of exposure to infectious diseases, including health care, death care, laboratories, airline operations, border

protection, solid waste and wastewater management, occupations that require travel to key areas.

- Incorporating the hierarchy of controls, utilizing engineering controls as the first line of defense.
- Recommending NIOSH-certified N95 respirators or better and other PPE for health care and other workers at an elevated risk.
- Outlining a risk-based model for many workers who require different levels of protection depending on the tasks they are performing and their potential exposures.

The United States must learn from previous infectious disease outbreaks.

This coronavirus, SARS-CoV-2, is in the same family of viruses as Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS). A global SARS outbreak was recognized in 2003 and 8,096 people across 29 countries were infected, 774 of them fatally.^x A global MERS outbreak was recognized in 2012 and 2,492 people across 27 countries were infected, resulting in 858 fatalities.^{xi} Additionally, although not caused by a coronavirus, in 2009 the H1N1 pandemic flu epidemic infected an estimated 60.8 million people and resulted in 12,469 deaths in the United States according to the CDC.^{xii}

Many lessons learned during the previous infectious disease outbreaks can be applied to help prevent COVID-19 from becoming as devastating as previous global infectious disease tragedies, or worse. The United States has always relied upon voluntary efforts by employers to protect workers from outbreaks, an approach that has proved to be woefully inadequate. After SARS, the Centers for Disease Control and Prevention (CDC) noted the need for the United States to be proactive, “Although the United States had a limited SARS outbreak, it is clear that we are susceptible to the more widespread outbreaks experienced in other countries.”^{xiii} In-depth studies of the SARS tragedy examined the failures and successes in identifying, treating, and preventing the spread of the virus.^{xiv} Some fatal mistakes included unclear and ineffective PPE recommendations, a delay in worker training, poor communication between public health agencies and hospitals, ineffective health and safety committees, blurred agency authority and accountability, inadequate medical surveillance, minimization of the role of worker safety and health agencies, and disregarding advice of workers on the frontline.^{xv} Specifically for health care workers, the precautionary principle that reasonable steps to reduce risk should not await scientific certainty was not implemented. During this outbreak, there was debate about the necessity of N95 respirators to protect health care workers. Some believed SARS was mostly spread through large droplets and surgical masks were sufficient. Since then, studies have indicated that airborne transmission requiring respiratory protection, not a surgical mask, is required. The failure to implement the precautionary principle in this crisis resulted in 45% of the infected in Ontario being health care workers.^{xvi}

Following the highly pathogenic avian influenza outbreak that began in 2003, the Bush Administration recognized the importance of preparing the nation for a pandemic and developed a National Strategy for Pandemic Influenza: Implementation Plan to limit and mitigate the domestic spread of a disease outbreak.^{xvii} Resources were requested and directed to developing preparedness plans, enhancing public health infrastructure and surveillance capacity, developing vaccines, and other critical needs. In addition, strategies were developed for sustaining infrastructure and reducing the impact of economic stress from an outbreak.^{xviii} Unfortunately, this national strategy and implementation plan has not been kept current nor modified or updated to address subsequent disease outbreaks.

While COVID-19 is the most recent global health threat, infectious disease outbreaks and other biological threats will continue to occur. Now is the time to plan to protect workers not only from this coronavirus, but also to learn from our past inaction to prevent a public health crisis.

An emergency temporary standard is needed to protect workers from the current coronavirus outbreak and future infectious agents.

There is no existing OSHA standard or basic regulatory framework that comprehensively addresses an employer's responsibility to protect workers from infectious diseases. In the absence of a set of mandatory infection control requirements that employers must implement, there is no assurance that all workers will be protected from infectious diseases like COVID-19.

Voluntary guidance versus requirements

Current efforts to protect workers from COVID-19 are largely voluntary. This allows each employer the discretion to implement, ignore, or selectively follow the guidelines issued by the agencies. Workers have the right to consistent levels of protection that will be implemented in all workplaces where occupational exposure to the coronavirus can be anticipated. In particular, health care workers and first responders must have the confidence that their employers will have a comprehensive health and safety program in place. If these workers are not protected from occupational exposures to COVID-19 or if they have a false sense of protection, they may infect the patients they care for or not come to work, which will jeopardize public health and the control of exposure to the pathogen. This is also true for transportation workers who are responsible for ensuring the safe transportation of both infected individuals and the public. Preparing for and protecting health care workers, emergency responders, and transportation workers at risk of exposure to coronavirus must be mandatory. Only an emergency temporary standard can quickly accomplish this objective.

Clear authority

Several agencies have published recommendations and guidance to prevent worker exposure to coronavirus. However, not all the recommendations are equally protective and employers do not have clarity and consistency on which agency to turn to. OSHA is the clear choice to issue direct, protective requirements, as their core legislative mandate is to ensure the safety and health of America's workforce by issuing mandatory and enforceable standards, including Emergency Temporary Standards.^{xix}

No safe exposure limit

There is no established safe exposure limit to an infectious agent like coronavirus. It is unknown how many infectious particles, or if even a single particle, is capable of causing an infection and disease. Therefore, the goal of worker protection efforts, including inhalation hazards, should be to eliminate exposure to coronavirus and other infectious agents to the greatest extent possible.

A comprehensive exposure control plan is necessary

The only way to prevent an outbreak or effectively limit the impact of an outbreak is for the United States to implement a strong and comprehensive public health approach to controlling exposure to infectious diseases. In the workplace, this requires a written exposure control plan, evaluation of the exposure control plan, exposure assessment, implementation of the hierarchy of controls, housekeeping measures, worker training, communication of hazards to employees, medical surveillance and vaccination program, medical removal protection, and recordkeeping/reporting; and employee involvement throughout the process.

A comprehensive approach in the workplace will implement the hierarchy of controls, including the use of personal protective equipment. In an infectious disease outbreak, clear and strong respiratory protection requirements are necessary. There is evidence of airborne transmission of respirable infectious agent particles (droplet nuclei) from coughing, sneezing, and merely talking. At a minimum, NIOSH-approved N95 filtering face piece respirators need to be worn by workers within the framework of a complete respiratory protection program as required under OSHA's respiratory protection standard, 1910.134. N95 respirators are designed to capture respirable particles and to provide a sufficient seal against the wearers' face to prevent significant leakage into the workers' breathing zone. The use of respirators, and the requirements under OSHA's respiratory protection standard provides protective measures required to address an outbreak, including training, fit testing, development of a written program, medical evaluation, use requirements, maintenance and care, recordkeeping, and program evaluation. Comprehensive requirements under an OSHA infectious disease standard would help prevent the equipment stockpile issues this country is currently facing, as employers would be prepared.

OSHA must move expeditiously to issue an ETS and can do so by utilizing the agency's long standing infectious disease rulemaking.

While OSHA does not have a standard to protect workers from infectious agents, like those causing the COVID-19 outbreak and could cause a pandemic, it does have a history of infectious disease rulemaking. Previously, OSHA has been petitioned by labor organizations to issue an emergency temporary standard for addressing pandemic influenza (2005) and to issue a rule for occupational exposure to infectious disease (2009). These petitions, and the threat of infectious disease pandemics such as SARS, West Nile virus, Lyme disease, zoonotic influenza and Ebola, led OSHA to place its infectious disease rulemaking on the Fall 2009 regulatory agenda. A request for information was issued in May 2010 and a Small Business Advocacy Review Panel (SBAR Panel) met and issued a report in January 2015. Despite this progress, infectious disease rulemaking was demoted in 2017 to be a long-term item on the regulatory agenda. Therefore, substantial work has already been completed by the agency and OSHA should take advantage of this record to issue a comprehensive emergency temporary standard.

The framework that OSHA submitted to the SBAR panel was a well-structured infection control program with elements including:

- (1) identification and isolation of infectious cases; (2) immunizations for vaccine-preventable diseases; (3) standard and transmission-based precautions; (4) training; (5) personal protective equipment; (6) management of healthcare workers' risks of exposure to infected persons, including post-exposure prophylaxis; and (7) work restrictions for exposed or infected healthcare personnel (Siegel et al., 2007). The prevention strategies listed above are set forth in guidelines, such as those of the Healthcare Infection Control Practices Advisory Committee (HICPAC), a federal advisory committee that provides advice and guidance to the CDC and to the Secretary of the Department of Health and Human Services (HHS).^{xx}

Existing OSHA standards can also be utilized to support the development of infectious disease protections, but these alone are not enough to mitigate exposures to infectious diseases at work. These standards include bloodborne pathogens (1910.1030), hazard communication (1910.1200), respiratory protection (1910.134), personal protective equipment (1910.132), and other various 6(b) health standards. Additionally, in developing an ETS, OSHA can draw from California OSHA's Aerosol Transmission Disease (ATD) Standard issued in 2009 in response to the pandemic flu, with health care, employer and union support, and tested during the H1N1 and Ebola and other disease outbreaks. The ATD standard protects employees in health care and other high-risk environments from inhaling viruses, bacteria, and other disease organisms.^{xxi} It is worth noting that these existing standards are not sector specific and protect all workers with potential or elevated exposure to biological and other hazards, just as all workers deserve protections from infectious disease such as coronavirus. The ATD standard covers the current coronavirus.

The Emergency Temporary Standard should, at a minimum, include the following provisions:

Scope and application

Facing exposure to infectious agents that can result in a pandemic, the scope of workers who need to be protected from an infectious disease must be comprehensive. In some workplaces, non-essential movement of people may be required, including the closing of schools, government offices, and other settings. The private sector may be encouraged, where possible, to establish protocols to allow workers to provide services from home. However, there are many workers whose occupations require them to treat and serve members of the public who may be infected and infectious. It is well documented that healthcare workers, emergency responders, and other employees are at an elevated risk of exposure during the performance of their job duties. However, it is not only those who directly provide care to patients known or suspected of being infected. Other occupations have a high likelihood of occupational exposure such as flight attendants and pilots, other public transportation workers, border and customs workers, corrections workers, housekeeping workers, maintenance and repair workers, other health care facility workers, food and medical supply workers, and others identified as “essential personnel” by employers. Therefore, the ETS should apply to all workers who perform essential functions and are at an elevated risk of occupational exposure to coronavirus. The standard should also apply to workers with close contact to potential zoonotic sources of infection.

Exposure Control Plan

An essential component to prevention of an outbreak is the creation and implementation of an exposure control plan. The exposure control plan determines which workers are at risk, and the activities and operations that put them at risk. An exposure control plan was a central tenant in OSHA’s infectious disease rulemaking and is contained in OSHA’s Bloodborne Pathogens Standard. The control plan in the ETS should be in writing and include:

- An exposure determination by occupation and activities for communicable and infectious agents that are present, or can reasonably be anticipated to be present. In the event of a pandemic, the exposure determination or hazard assessment must be a continuous process for the duration of the pandemic as the scope of activities and operation may change rapidly as well as the determination of at-risk workers.
- Procedures to provide information and training to employees about potential or actual occupational exposure to communicable and infectious agents.
- Procedures for reporting an incident.
- Medical surveillance procedures to identify suspected or confirmed cases of a communicable or infectious disease and a plan to isolate or transfer individuals.
- Methods of compliance, including appropriate engineering controls, work practices, and personal protective equipment.

- Recordkeeping.
- The name and title of the person(s) responsible for administering the plan. This person must be knowledgeable in infection control principles and practices as they apply to the facility, service or operation.

The employer must be required to periodically evaluate the effectiveness of the exposure control plan. Additionally, when developing and evaluating the plan, employers should be required to solicit input from all workers who are at risk of potential exposure.

Methods of Compliance

The methods of compliance should include the hierarchy of controls and a schedule for implementation.

Engineering Controls

The hierarchy of controls is longstanding and widely accepted industrial hygiene practice. As the top of the hierarchy of controls, (after elimination and substitution, which cannot be done for an infectious agent) engineering controls must be a required component of the ETS. This is particularly essential for coronavirus given the unknowns surrounding its potential to cause infection, the virulence of the virus, and the absence of an established threshold exposure capable of causing infection. Ventilation, portable high-efficiency particulate air (HEPA) filtration units, negative pressure isolation rooms and other controls should be used to reduce the number of infectious particles in the air.

Administrative Controls

Work practice and other administrative controls can minimize employee exposure by combining tasks to limit the number of entries into a room or area with known or suspected infected individuals. In addition, high-hazard, non-priority work can be delayed until the infection risk has been reduced. In the health care setting, this includes ensuring that engineering controls, such as negative air pressure and filtration systems are in place before performing high-hazard procedures or surgeries. Employers should adopt practices to minimize worker fatigue in widespread outbreaks, such as adequate rest and shift breaks. Fatigue can contribute to workers' inability to effectively use personal protective equipment during an outbreak.

Personal Protective Equipment

All employers who have workers who are at an elevated risk of occupational exposure to coronavirus or other infectious agents must provide appropriate personal protective equipment (PPE). This includes a N95 respirator as the absolute minimum level of personal respiratory protection allowed and in compliance with OSHA's respiratory protection standard 1910.134. Respirators that are more protective should also be considered, and may be required based on

assessed risk. The use of less protective PPE, including ineffective surgical masks, would be dangerous, ineffective and inappropriate. The ETS should also require the use of gloves, gowns, and other equipment according to OSHA's PPE standard 1910.132. This is particularly necessary because this virus has multiple routes of transmission, including fecal matter.^{xxii}

The standard should also include additional considerations for high-hazard procedures. For example, when procedures cannot be delayed, they should be conducted in isolation rooms or other areas with appropriate ventilation and respirators with higher assigned protection factors than a N95 should be required.

Medical surveillance, medical removal protection, and vaccinations

Medical surveillance to monitor at risk workers for illness and to manage those who are symptomatic is essential for both protecting the health of employees as well as to avoid the spread of the virus to co-workers, patients, or others they serve. The ETS must include screening requirements to all workers for symptoms of infection before they come on duty. Symptomatic workers should be sent home until they are physically ready to return to work and cleared by a physician or licensed health care provider. The employer must provide any necessary post-exposure treatment or medical monitoring to exposed workers. The ETS must include requirements for medical removal protection (MRP) so that workers will suffer no loss of employment, pay, benefits, seniority, or other rights during the duration of their illness. MRP is essential to ensuring workers are vigilant about their own health and potential to infect others while not sacrificing their livelihood. A failure to guarantee pay and benefits serves as a disincentive to report symptoms and stay home from work—and if the worker is infected, to spread the infection to patients, co-workers, or the public.

As of this petition, a vaccine is not yet available to address the COVID-19 outbreak. However, if immunizations become available, health care workers, emergency responders, and other high-risk occupations should be prioritized to receive the vaccine. However, vaccination is a personal choice and should be voluntary in nature. No worker should suffer any form of discipline or discrimination for refusing to be vaccinated. Vaccines should be made available at no cost to the employee and at a reasonable time and place. This is in line with OSHA's bloodborne pathogens provisions (1910.1030). Voluntary vaccination programs are one element of a comprehensive approach to protecting workers against infectious diseases—not an exclusive remedy.

Housekeeping

The ETS should include requirements for disposal of infectious waste, laundry, dishes, and eating utensils, patient-care equipment, environmental cleaning and disinfection, and other measures deemed necessary to reduce exposure.

Communication of hazards and training

The ETS should include requirements to properly label objects and containers of potentially infectious materials according to the hazard communication standard (1910.1200). Additionally, warning signs should be posted at the entrance of work areas where there is potential exposure.

Training should be required to ensure that all workers with potential occupational exposure receive training on the symptoms associated with COVID-19, modes of transmission, control methods and their limitations, vaccinations, the medical surveillance program, and other information necessary for worker protection and pandemic prevention. The training must be provided during working hours and the training materials be given in appropriate content and vocabulary to the education, literacy and language of the workers receiving the training. Training should be systematically updated as new research and guidance on effective exposure prevention strategies becomes available.

Recordkeeping

The ETS should include requirements for employers to maintain records for each employee with occupational exposure in accordance with OSHA's recordkeeping standards and access to exposure monitoring and medical records. The medical records should be maintained in accordance with modern Health Insurance Portability and Accountability Act (HIPAA) protocols. OSHA can utilize their silica (1910.1053) and beryllium (1910.1024) standards to issue these provisions.

In conclusion, the imminent threat of pandemic coronavirus demands a swift and comprehensive strategy to protect workers who are exposed to respond to the needs of the public during an outbreak. In the face of no infectious disease standard, OSHA must act now. There is already a global crisis, and the United States must prepare before an outbreak occurs at home. Preparedness is only effective if it includes a comprehensive framework to protect the health and safety of workers on the frontlines of protecting and treating the public during a health crisis. OSHA has the authority and responsibility to protect the health and safety of America's workers. The magnitude and urgency of a coronavirus pandemic cannot be minimized and OSHA must issue an Emergency Temporary Standard for Infectious Diseases to ensure that workers will be protected from all infectious diseases, including COVID-19.

The COVID-19 outbreak is another tragic reminder that the U.S. is not prepared to adequately protect workers on the frontlines from infectious diseases. We urge the Department of Labor to swiftly issue an Emergency Temporary Standard to protect workers from infectious diseases. As unions have a plethora of experience protecting our members on the frontline from infectious diseases and have been integrally involved in government activities surrounding pandemic preparedness for decades,

The Honorable Eugene Scalia
March 6, 2020
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We urge the administration to work with us through the issuance of an ETS and in developing a final standard to protect workers from infectious diseases.

Sincerely,



Richard L. Trumka
President

Actors' Equity Association, AEA
American Federation of Government Employees, AFGE
American Federation of Teachers, AFT
Association of Flight Attendants-CWA, AFA-CWA
Communications Workers of America, CWA
Department for Professional Employees, DPE, AFL-CIO
National Association of Letter Carriers, NALC
International Association of Machinists and Aerospace Workers, IAM
International Association of Sheet Metal, Air, Rail and Transportation Workers, SMART
International Brotherhood of Teamsters, IBT
International Federation of Professional and Technical Engineers, IFPTE
International Union, United Automobile, Aerospace & Agricultural Implement Workers of America, UAW
New York State Nurses Association
New York State Public Employees Federation, AFL-CIO
American Postal Workers Union, APWU
Service Employees International Union, SEIU
Stage Directors and Choreographers Society, SDC
Transportation Trades Department, TTD, AFL-CIO
Transport Workers Union of America, TWU, AFL-CIO
Transportation Communications Union (TCU/IAM)
United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, USW
Utility Workers Union of America, UWUA

CC: Loren Sweatt, Principal Deputy Assistant Secretary of Labor for Occupational Safety & Health

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^{xxi} See Title 8 CCR; Section 5199.

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