AMERICAN COLLEGE OF
OCCUPATIONAL AND
ENVIRONMENTAL MEDICINE

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October 17, 2025

Ms. Amanda Laihow
Acting Assistant Secretary of Labor for Occupational Safety and Health
U.S. Department of Labor
Occupational Safety and Health Administration
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Re: Department of Labor Occupational Safety and Health Administration 29 CFR Parts 1910, 1915, 1917, 1918, 1926, and 1928 [Docket No. OSHA-2020-0004] RIN 1218-AD36

Dear Acting Assistant Secretary Laihow:

On behalf of the American College of Occupational and Environmental Medicine (ACOEM), I am writing to provide comments on the above-referenced proposed rulemaking.

About ACOEM

Founded in 1916, ACOEM is a national medical society representing over 3,000 occupational medicine physicians and other health care professionals devoted to promoting optimal health and safety of workers, workplaces, and environments. ACOEM is dedicated to improving the care and well-being of workers through science and the sharing of knowledge. Our members work in corporations, hospitals, clinics, academic medical centers, government, etc. and are committed to the highest standards of patient care and workplace safety.

ACOEM actively participates in healthcare policy development, advocates for evidence-based medical practice standards, and works to ensure that regulatory requirements support both patient safety and provider well-being. The association provides continuing medical education, professional development resources, and serves as a voice for physicians in healthcare policy discussions at the state and federal levels.

Position Statement

ACOEM supports this deregulatory action and recommends full rescission of the remaining ETS provisions in 29 CFR 1910.502(q)(2)(ii), (q)(3)(ii)-(iv), and (r). because they are duplicative of existing OSHA recordkeeping, provide no incremental worker protection, divert resources from higher-impact

prevention, are misaligned with current endemic management of respiratory pathogens, and, by OSHA's own recent posture, are no longer necessary.

Our rationale is as follows:

1) Duplicative with established OSHA recordkeeping; no added protective value
Healthcare employers already record occupational illnesses, including COVID-19, on the OSHA 300/301 logs where cases meet recordability criteria. Requiring a separate COVID-19 case log and special reporting steps under 1910.502(q) adds parallel paperwork without improving hazard control, exposure response, or outcomes for workers. Internal experience across member organizations shows the COVID-specific log has not generated actionable insights beyond what standard logs and case investigations already provide. Instead, it creates dual systems that increase workload while delivering no incremental protection. Immediate return-to-work counseling for infected employees and rapid notification and guidance for exposed coworkers are driven by case management and infection control protocols—not by maintaining a special log—making the COVID log superfluous to time-sensitive, protective action.

2) Core reporting duties remain intact without the ETS provisions
Eliminating 1910.502(q)(2)(ii), (q)(3)(ii)-(iv), and (r) would not change employers' obligations to record and report serious work-related COVID-19 outcomes (e.g., fatalities within the reporting window, in-patient hospitalizations) under OSHA's longstanding reporting rules. Those established requirements ensure severe outcomes remain visible to OSHA and public health without a parallel, pathogen-specific administrative layer. In short, the ETS provisions are redundant rather than protective.

3) Inefficient use of limited occupational health resources
Maintaining a dedicated COVID-19 log diverts staff and systems from higher-yield controls. Occupational health and infection prevention teams can better protect workers by focusing on:

- Robust identification and assessment of employees and patients with communicable respiratory illnesses,
- Reducing opportunities for transmission through engineering, administrative, and work-practice controls appropriate to risk,
- Rapid identification and management of high-risk exposures, and
- Counseling, isolation, and return-to-work aligned with current public health guidance.

Reallocating time and resources away from duplicative recordkeeping toward these core interventions yields greater risk reduction and more timely protection for healthcare personnel.

4) Misaligned with current science and endemic respiratory risk management
COVID-19 has shifted from an acute pandemic phase to endemic circulation alongside other respiratory pathogens such as influenza and RSV. Continuing pathogen-specific recordkeeping requirements for COVID-19 alone is inconsistent with an all-hazards, risk-based approach that prioritizes controls by exposure scenario and severity rather than pathogen identity. Aligning COVID-19 case tracking with existing OSHA logs and standard exposure management strengthens coherence, reduces confusion, and supports integrated respiratory protection programs that address multiple agents effectively.

5) Regulatory clarity and burden reduction, consistent with OSHA's current stance
OSHA has already indicated that it is no longer enforcing the COVID-19-specific recordkeeping obligations unique to the ETS framework. Formal rescission of 1910.502(q)(2)(ii), (q)(3)(ii)-(iv), and (r) would harmonize regulation with current practice, remove uncertainty for employers, and end administrative waste associated with maintaining a nonessential, unenforced layer. Clear removal will help organizations streamline compliance systems, reinforce focus on established 300/301 recordkeeping, and concentrate effort on the preventive measures that matter most for worker health and safety.

In conclusion, OSHA should rescind the remaining COVID-19 ETS recordkeeping and reporting provisions in 29 CFR 1910.502(q)(2)(ii), (q)(3)(ii)-(iv), and (r). Doing so will eliminate duplicative and unenforced requirements, preserve effective baseline recording and reporting for serious outcomes, align occupational health practice with current endemic respiratory risk management, and free resources to implement higher-impact protective strategies for healthcare workers. This action advances regulatory clarity and strengthens practical protection without compromising transparency or safety.

For more information about ACOEM, please visit acoem.org or contact Craig Sondalle, CEO at craig@acoem.org.

Sincerely,

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