detectors must be MSHA-approved and maintained in permissible and proper operating condition as required under § 75.320.

(2) All methane detectors must provide visual and audible warning signals when methane is detected at or above 1.0 percent.

(b) When 1.0 percent or more of methane is detected, the electronic surveying equipment must not be energized or must be immediately deenergized if in use and immediately withdrawn from specified underground areas to outby the last open crosscut, out of the return, or more than 150 feet from pillar workings or longwall faces under § 75.323.

§ 75.1805 Requirements for the use of electronic surveying equipment on a mechanized mining unit where production activities are occurring.

On a mechanized mining unit where production activities are occurring, the following requirements must be met.

(a) Electronic surveying equipment may be used except as provided in paragraphs (a)(1) and (a)(2) of this section:

(1) Electronic surveying equipment must not be used downwind of the discharge point of any face ventilation controls, such as tubing or curtains.

(2) Electronic surveying equipment must not be used in a split of air ventilating a mechanized mining unit.

(b) Electronic surveying equipment must not be used within 150 feet of pillar workings or longwall faces.

(c) When surveying cannot be completed with ventilation controls in place, the underground mine surveyor must notify the mine operator for approval of any changes. All changes must comply with approved ventilation plans.

(1) Before and while any ventilation controls are changed, all production activities must cease in areas affected by the change.

(2) Once production activities cease and approved ventilation changes have been completed, a certified person must notify underground mine surveyors when surveying may resume.

(3) Ventilation controls must be reestablished immediately after the change is no longer necessary.

(4) Production activities may resume only after all ventilation controls are reestablished and are in compliance with the approved ventilation plan.

§ 75.1806 Requirements for batteries contained in electronic surveying equipment.

(a) Before each shift of surveying, all batteries for the electronic surveying equipment must be charged sufficiently to function the entire shift.

(b) Replacement batteries for electronic surveying equipment must be carried underground only in the compartment provided for a spare battery pack in the electronic surveying equipment carrying case. Replacement batteries must not be taken into the specified underground areas.

(c) Batteries contained in the electronic surveying equipment must be changed out in intake air outside of the specified underground areas.

(d) No batteries may be charged underground.

§ 75.1807 Electronic surveying equipment maintenance and examination.

(a) All electronic surveying equipment must be maintained to ensure safe operating condition. When a potentially dangerous condition is found with the equipment, such equipment must be immediately withdrawn from the specified underground areas and taken out of service and must be repaired before returning to service.

(b) As specified under § 75.1803(a), electronic surveying equipment must be examined weekly by a qualified person as defined by § 75.153 to assure safe operating condition.

(c) The mine operator must ensure that all electronic surveying equipment is serviced according to the manufacturer's recommendations.

§ 75.1808 Training.

(a) Miners and underground mine surveyors who will be involved with or affected by electronic surveying operations must be trained on the requirements of this subpart before the electronic surveying equipment can be used.

(b) Mine operators must train new miners and underground mine surveyors under § 48.5, train experienced miners and surveyors, under § 48.6, and train miners and surveyors assigned new work tasks under § 48.7 on the requirements of this subpart. The training must include hazard recognition specific to the mine.

(c) Mine operators must provide annual retraining to all miners and underground mine surveyors involved with or affected by surveying operations under § 48.8.

(d) Miners and underground mine surveyors using electronic surveying equipment must be trained to recognize the hazards and limitations associated with the use of electronic surveying equipment in the areas where methane could be present.

(e) Records of training required under this part must comply with part 48.

(f) Mine operators must provide such records to MSHA upon request.

James P. McHugh,

Deputy Assistant Secretary for Policy, Mine Safety and Health Administration.

[FR Doc. 2025–11741 Filed 6–30–25; 8:45 am]

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DEPARTMENT OF LABOR

Occupational Safety and Health Administration

29 CFR Part 1910

[Docket # OSHA–2025–0006]

RIN 1218–AD48

Amending the Medical Evaluation Requirements in the Respiratory Protection Standard for Certain Types of Respirators

AGENCY: Occupational Safety and Health Administration, Department of Labor.

ACTION: Proposed rule; request for comments.

SUMMARY: OSHA is proposing to remove some medical evaluation requirements in the Respiratory Protection Rule for certain types of respirators. This proposed change would only impact filtering facepiece respirators and loose-fitting powered air-purifying respirators.

DATES: Comments must be received on or before September 2, 2025.

Informal public hearing: OSHA will schedule an informal public hearing on the proposed rule if requested during the comment period. If a hearing is requested, the location and date of the hearing, procedures for interested parties to notify the agency of their intention to participate, and procedures for participants to submit their testimony and documentary evidence will be announced in the **Federal Register**.

ADDRESSES:

Written comments: You may submit comments and attachments, identified by Docket No. OSHA–2025–0006, electronically at *http://www.regulations.gov, which is the Federal e-Rulemaking Portal. Follow the instructions online for making electronic submissions.*

Instructions: All submissions must include the agency's name and the docket number for this rulemaking (Docket No. OSHA–2025–0006). All comments, including any personal information that is provided, are placed in the public docket without change and may be made available online at *http://www.regulations.gov. Therefore, OSHA*

cautions commenters about submitting information they do not want made available to the public, or submitting materials that contain personal information (either about themselves or others), such as Social Security Numbers and birthdates.

When uploading multiple attachments to *http://www.regulations.gov, please number* all of your attachments because *http://www.regulations.gov* will not automatically number the attachments. This numbering will be very useful in identifying all attachments in the preamble for the final rule. For example, Attachment 1—title of your document, Attachment 2—title of your document, Attachment 3—title of your document. For assistance with commenting and uploading documents, please see the Frequently Asked Questions on *http://www.regulations.gov.*

Docket: To read or download comments or other materials in the docket, go to Docket No. OSHA–2025–0006 at *http://www.regulations.govthe http://www.regulations.gov* index; however, some information (*e.g.,* copyrighted material) is not publicly available to read or download through that website. All comments and submissions, including copyrighted material, are available for inspection through the OSHA Docket Office. Documents submitted to the docket by OSHA or stakeholders are assigned document identification numbers (Document ID) for easy identification and retrieval. The full Document ID is the docket number plus a unique four-digit code. Some Document ID numbers also include one or more attachments.

When citing exhibits in the docket, OSHA includes the term ''Document ID'' followed by the last four digits of the Document ID number. For example, document OSHA–2025–0006 would appear as ''Document ID 0006.'' Citations also include the attachment number or tab number, if applicable. In a citation that contains two or more Document ID numbers, the Document ID numbers are separated by semi-colons (*e.g.,* ''Document ID 1231, Attachment 1; 1383, Attachment 1''). OSHA may also cite items that appear in another docket. When that is the case, OSHA includes the full document ID for the corresponding docket entry.

This information can be used to search for a supporting document in the docket at *http://www.regulations.gov.* Contact the OSHA Docket Office at (202) 693–2350 (TTY number: 877–889–5627) for assistance in locating docket submissions.

FOR FURTHER INFORMATION CONTACT:

For press inquiries: Contact Frank Meilinger, Office of Communications, Occupational Safety and Health Administration, U.S. Department of Labor; telephone (202) 693–1999; email *oshacomms@dol.gov.*

For general information: Contact Andrew Levinson, Director, Directorate of Standards and Guidance, Occupational Safety and Health Administration, U.S. Department of Labor; telephone (202) 693–1950; email: *osha.dsg@dol.gov.*

For copies of this ***Federal Register*** *document:* Electronic copies of this **Federal Register** notice are available at *http://www.regulations.gov.* This notice, as well as news releases and other relevant information, are also available at OSHA's web page at *www.osha.gov.* A 100-word summary of this proposed rule is available on *http://www.regulations.gov.*

SUPPLEMENTARY INFORMATION:

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I. Background

A. Executive Summary

In 1971, the Occupational Safety and Health Administration (OSHA) adopted the American National Standards Institute (ANSI) standard Z88.2 1969, ''Practices for Respiratory Protection,'' as well as ANSI Standard K13.1 1969, ''Identification of Gas Mask Canisters'' as its standard for respiratory protection. In April of 1971, OSHA promulgated 29 CFR 1926.103, the initial respiratory protection standard for the construction industry. On February 9, 1979, OSHA announced that 29 CFR 1910.134 would be formally recognized as also being applicable to the construction industry (44 FR 8577). On November 15, 1994, OSHA issued a Notice of Proposed Rulemaking to revise 29 CFR 1910.134 (59 FR 58884). On January 8, 1998, OSHA issued a Final Rule in the **Federal Register** (63 FR 1152) revising 29 CFR 1910.134. The prior respirator standard was re-designated as 1910.139 and applied only to respiratory protection against M. tuberculosis (TB). On December 31, 2003, OSHA withdrew 1910.139 and made compliance with 1910.134 effective immediately (68 FR 75776). On August 24, 2006, OSHA published revisions to the 1910.134 Final Rule, to add definitions and requirements for Assigned Protection Factors (APFs) and Maximum Use Concentrations (MUCs) (71 FR 50122). The revisions also supersede the respirator selection provisions of existing substance-specific standards with these new APFs (except for the respirator selection provisions of the 1,3-Butadiene Standard).

The current OSHA Respiratory Protection Standard (29 CFR 1910.134) aims to protect workers from inhaling hazardous airborne contaminants (*e.g.,* dusts, fogs, fumes, mists, gases, smokes, sprays, vapors) in the workplace by requiring employers to establish a comprehensive written respiratory protection program that includes procedures for respirator use, training, and fit testing. A key component of this program is medical evaluation, which determines whether employees are physically able to wear respirators safely. Before using a respirator, employees must be evaluated by a physician or other licensed health care professional (PLHCP), using the mandatory OSHA medical questionnaire or an equivalent method, to assess medical conditions that could interfere with respirator use, such as cardiovascular or pulmonary diseases. A medical evaluation helps ensure that any employee required to use a respirator can tolerate the physiological burden associated with respirator use which is crucial to ensure worker safety. Additionally, the standard mandates fit testing for tight-fitting facepiece respirators, training on proper use and maintenance, and ongoing monitoring of workplace conditions to ensure the selected respirators provide adequate protection. The program must be regularly evaluated for compliance and effectiveness, with records maintained for medical evaluations, fit testing, and training, to reduce the risk of respiratory-related occupational illnesses.

OSHA is proposing an update to the Respiratory Protection Standard to amend the medical evaluation requirements specified in paragraph (e) where an employee is required to wear either a filtering facepiece respirator (FFR) or loose-fitting powered air-purifying respirator (PAPR) and seeks comment on all aspects of this proposal. Using a respirator may place a physiological burden on employees that varies with the type of respirator worn, the job and workplace conditions in

which the respirator is used, and the medical status of the employee. OSHA has preliminarily determined this burden differs based on the type of respirator worn and therefore proposes an amendment to the medical evaluation requirements of the standard for FFRs and loose-fitting PAPRs.

B. Health Literature Background

Introduction

In this section, OSHA provides an overview of the agency's evidence to determine whether this proposed rule impacts material impairment of health. The Secretary's material impairment determinations must be made ''on the basis of the best available evidence'' and must consider the ''latest available scientific data in the field'' (29 U.S.C. 655(b)(5)). This overview briefly acknowledges the original basis for the determination of a need for medical evaluations before using FFRs and loose fitting PAPRs as well as considers research published after the promulgation of that rule.

OSHA concludes that the data available for health effects are lacking and insufficient to establish that medical evaluations meaningfully reduce material impairment caused by wearing an FFR or a loose fitting PAPR. Even though ''OSHA is not required to state with scientific certainty or precision the exact point at which each type of [harm] becomes a material impairment'' (*AFL–CIO* v. *OSHA,* 965 F.2d 962, 975 (11th Cir. 1992)), the level of evidence in the following discussion is unconvincing as it pertains to the ability of medical evaluations to prevent material impairment induced by the wearing of FFRs or PAPRs. The Occupational Safety and Health Act (29 U.S.C. 651, *et seq.*) (''the Act'' or ''the OSH Act'') charges OSHA with addressing all forms of material impairment, not just death or serious physical harm (*Id.*). The agency acknowledges that respirators may negatively impact some workers' health due to extreme exertion while wearing one, impact on communication or ability to see, triggering mental health concerns (*e.g.,* claustrophobia), and other impacts on their quality of life. However, medical evaluation before use of an FFR or loose fitting PAPR is not well evidenced to prevent these outcomes.

Original Basis of the Medical Questionnaire Requirement

When OSHA developed the respiratory protection standard in the 1990s, the use of medical evaluations to identify underlying conditions where respirator use could cause material impairment was a well-accepted best practice. This process was ''derived from studies of Navy SCUBA (self-contained underwater breathing apparatus) or military users under conditions unlike most current use'' (Harber et al., 2025). For the proposed standard (''Respiratory Protection Standard; Proposed Rule, 59 FR 58884), OSHA gathered information and presented for comment several alternatives ranging from in-person medical evaluations by physicians, exempting workers who use respirators for less than five hours a week, or using medical questionnaires presented by a PLCHP as a screening tool before a medical evaluation would be required. From this robust stakeholder engagement process, OSHA concluded that medical questionnaires would be permitted as a screening tool to identify individuals for whom an in-person medical examination would then be required in the final rule (63 FR 1152–1300). The questionnaire was adapted from ANSI Z88.6–1984.

In the 1998 final rule (63 FR 1210), OSHA determined that there existed ''the potential for adverse health effects resulting from respirator use, even for healthy employees using respirators designed for low breathing resistance and used for short durations.'' OSHA also found that ''respirator use would impose a substantial risk of material impairment to the health of employees who have preexisting respiratory and cardiovascular impairments.'' Based on the results of studies in the record as well as the comments received, OSHA determined ''the use of any respirator requires a prior medical evaluation to determine fitness.''

OSHA now believes that the requirement for medical evaluations before the use of any type of respirator is too broad in practice; specifically with respect to the use of FFRs and loose fitting PAPRs. Even the 1998 final rule included two commenters who expressed that medical limitations on their workforce were fairly limited with Organization Resources Counselors, Inc (Ex. 54–424) noting that 2% of their workforce were limited based on claustrophobia, asthma, and heavy smoking and Boeing (Ex. 54–445) reporting that 1–2% of their workforce was limited due to not undergoing the evaluation or because of employee preference (63 FR 1213, 1219). While 2% of the workforce is a small yet significant number, it does not identify actual avoided adverse outcomes from wearing a respirator. While it may have been reasonable to avoid this increased risk at the time, the agency concludes that it is important to consider new evidence in the years since the rule was published.

Lack of Data Showing Material Impairment Avoided by Medical Evaluations

i. Lack of large scale epidemiological studies.

The use of medical evaluations in respiratory protection programs as a prospective measure to avoid adverse health outcomes remains a well-accepted best practice. However, the agency is not aware of any epidemiological studies that evaluate their efficacy for FFRs and loose fitting PAPRs.

Many workers currently use FFRs and loose fitting PAPRs without medical evaluations. For instance, NIOSH found that in the immediate wake of the publishing of the 1998 Respiratory Protection Standard 51.2% of an estimated 281,776 establishments may not have performed medical evaluations to determine fitness for wearing a respirator (Doney et al., 2005). A 2015 study (Brousseau et al., 2015) reported that 14% of hospital workers in Illinois and 23% in Minnesota did not receive a medical evaluation. Medical evaluations are likely far less prevalent in many industries with smaller and more dispersed workforces. For instance, workers in hog farms commonly wear respirators, predominantly N95s, when performing some tasks, but are generally not subject to the Respiratory Protection Standard and are likely not following it (Gibbs et al., 2020). The agency knows of no data related to these worker populations showing that the lack of medical evaluations is causing adverse health effects. OSHA requests comment on the extent to which medical evaluations are effective at preventing adverse health outcomes resulting from the use of FFRs and loose-fitting PAPRs.

ii. Despite large increases in respirator usage after the emergence of COVID–19, no evidence has surfaced illustrating the need for medical evaluations for FFR and PAPR usage.

FFR and PAPR usage increased immensely after the emergence of COVID–19. Workers across industries performing a wide variety of tasks were suddenly wearing these respirators, often for their entire shifts every work day. Despite this sudden increase~~d~~ and widespread usage of these respirators, often without a medical evaluation, the agency is not aware of any data identifying adverse outcomes from individuals with underlying medical conditions during the COVID–19 pandemic. OSHA requests comment on

the extent to which workers have worn FFRs and loose-fitting PAPRs without medical evaluations since the emergence of COVID–19 in 2020.

With this lack of data about medical evaluation efficacy for FFRs and loose fitting PAPRs, it is difficult to reaffirm that medical evaluations are either necessary or appropriate for preventing adverse health outcomes.

iii. Few workers are refused respirators.

As noted earlier, the data reported in the final rule for Respiratory Protection (29 CFR 1910.134) found that 2% or fewer workers did not pass the medical evaluation. That proportion appears to be fairly consistent with more recent studies. A 1999 study (Pappas et al.) found that out of 5,569 workers who had a medical evaluation only 1.3% had limitations placed upon their work and 0.2% were denied use. Pregnancy was the reason for denial and the researchers found that physical examination and spirometry added nothing to the analysis. A 2017 study (Desai et al.) found that only 1.48% of 337 subjects who passed the medical questionnaire evaluation failed the spirometry test under the American Thoracic Society criteria. In a survey of 35 clinics or clinic groups, Harber et al. (2025) found that nearly all workers were approved without restrictions and it was considered very unusual to decline approval.

In practice, few workers have their respirator use limited. Additionally, we currently have no ability to estimate, to the agency's knowledge, how many adverse events are being avoided by restricting the use of FFRs and PAPRs by workers. As such, it is difficult to ascertain whether there is material impairment in these scenarios if a worker who should be restricted is permitted to use a respirator. OSHA requests comment on how many adverse events are being avoided by restricting the use of FFRs and PAPRs by workers.

iv. Workers are able to respond quickly when symptoms arise.

In the apparently rare circumstance that a worker develops symptoms from wearing an FFR or loose-fitting PAPR, these scenarios are not Immediately Dangerous to Life or Health (IDLH) situations. This is so because FFRs and loose fitting PAPRs are not permitted to protect employees in IDLH environments. Therefore, the worker should be able to seek safety with an exposure well below expected thresholds for adverse health outcomes. This is in contrast to other respirators—(*e.g.,* self-contained breathing apparatus (SCBA)—) that would be required in more dangerous exposure environments.

v. Available data on effects largely shows minimal impact on health.

As noted in the original rule (63 FR 1152–1300), self-contained breathing apparatus (SCBA) respirators require a great deal of exertion given the weight of that apparatus. However, the body of literature does largely agree that any physiological effects from wearing much lighter FFRs and PAPRs are minimal during low to moderate exertion. In studies assessing cardiovascular parameters, FFRs and PAPRs did not significantly impact health in low to moderate exercise scenarios that would be typical of the vast majority of workplaces (Epstein et al., 2020; Anil et al., 2023). Similarly, Rothstein et al. studied 42 individuals who did not have a history of claustrophobia or metabolic disease and found that individuals who wore N–95 respirators displayed minor changes in respiratory and metabolic effects, but those ''physiological parameters remained within normal ranges at rest and would not impact daily functioning'' (Rothstein et al., 2025). A limitation on these studies is that they are performed on populations that screen out unhealthy individuals (*e.g.,* smokers, known cardiovascular issues), but one would surmise that changes in physiological parameters would be observable even in healthy individuals and this does not seem to be the case. It is reasonable to assume that work that requires high exertion could impact the health of a wearer, but that high exertion work likely self-selects for individuals who would be medically fit to wear an FFR or a PAPR.

The 1998 final rule also noted some concern about non-physiological impacts, specifically noting claustrophobia. A more recent look into the evidence found that the notion of large numbers of workers experiencing claustrophobia is unfounded (Harber and Beckett, 2023). In a letter to the editor, McClellan (2020) found that full-shift work using an FFR could cause issues, such as psychological stresses, that result in the wearer feeling compelled to remove their respirator in potentially unsafe situations. While psychological stressors have been observed and can induce physiological impairment, the agency is unable to adequately qualify the degree to which this occurs in the affected workplaces. And, as noted above, if a worker wearing an FFR or loose fitting PAPR had to remove their respirator due to psychological distress, the worker would necessarily not be exposed to an IDLH atmosphere but would rather be able to seek safety with an exposure well below expected thresholds for adverse health outcomes.

Conclusion

The agency preliminarily concludes that there is not sufficient evidence to conclude that wearing FFRs and loose fitting PAPRs without a prior medical evaluation can result in unavoidable adverse outcomes, and that the assumption that medical evaluation effectively detects risk for adverse effects from the occupational use of FFRs and loose fitting PAPRs is unproven.

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II. Discussion

A. Pertinent Legal Authority

The purpose of the OSH Act is ''to assure so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources'' (29 U.S.C. 651(b)). To achieve this goal Congress authorized the Secretary of Labor (''the Secretary'') to promulgate standards to protect workers, including the authority ''to set mandatory occupational safety and health standards applicable to businesses affecting interstate commerce'' (29 U.S.C. 651(b)(3); *see also* 29 U.S.C. 654(a)(2) (requiring employers to comply with OSHA standards), 29 U.S.C. 655(a) (authorizing summary adoption of existing consensus and established federal standards within two years of the Act's enactment), 29 U.S.C. 655(b) (authorizing promulgation, modification or revocation of standards pursuant to notice and comment), and 29 U.S.C. 655(b)(7) (authorizing OSHA to include among a standard's requirements labeling, monitoring, medical testing, and other information-transmittal provisions)). An occupational safety and health standard is ''. . . a standard which requires conditions, or the adoption or use of one or more practices, means, methods, operations, or processes, *reasonably necessary or appropriate* to provide safe or healthful employment and places of employment'' (29 U.S.C. 652(8) (emphasis added)). A standard is reasonably necessary or appropriate within the meaning of section 652(8) if it substantially reduces or eliminates significant risk or prevents it from developing, and is economically and technologically feasible, cost effective, consistent with prior Agency action or supported by a reasoned justification for departing from prior Agency actions, and supported by substantial evidence. *See Am. Textile Mfrs. Institute, Inc.* v. *Donovan,* 452 U.S. 490 (1981); 58 FR 16612.-16616. The Secretary may also issue regulations requiring employers to keep records regarding their activities relating to the Act, as well as records of work-related deaths, injuries, and illnesses (29 U.S.C. 657(c)(1)–(2)).

As required by the OSH Act, OSHA originally determined that the respiratory protection standard would substantially reduce a significant risk of material harm when promulgating the standard. For the changes in this proposed rule, OSHA has not made a new finding of significant risk but is making changes that are reasonably related to the purpose of the respiratory protection standard as a whole. When, as here, OSHA has previously determined that its standard substantially reduces a significant risk, it is unnecessary for the agency to make additional findings on risk for every provision of that standard. *See, e.g., Pub. Citizen Health Research Grp.* v. *Tyson,* 796 F.2d 1479, 1502 n.16 (D.C. Cir. 1986) (rejecting the argument that OSHA must ''find that each and every aspect of its standard eliminates a significant risk''). Rather, once OSHA makes a general significant risk finding in support of a standard, the next question is whether a particular requirement is reasonably related to the purpose of the standard as a whole. *See Asbestos Info. Ass'n/N. Am.* v. *Reich,* 117 F.3d 891, 894 (5th Cir. 1997); *Forging Indus. Ass'n* v. *Sec'y of Labor,* 773 F.2d 1436, 1447 (4th Cir. 1985); *United Steelworkers of Am., AFL–CIO–CLC* v. *Marshall,* 647 F.2d 1189, 1237–38 (D.C. Cir. 1980) (''*Lead I*'').

The Act also provides that in promulgating standards dealing with toxic materials or harmful physical agents, OSHA must set the standard that ''most adequately assures, to the extent feasible, on the basis of the best available evidence, that no employee will suffer material impairment of health or functional capacity even if such employee has regular exposure to the hazard dealt with by such standard for the period of his working life'' (29 U.S.C. 655(b)(5)). As discussed in Section IB, Health Literature Background, OSHA concludes that the data available for health effects are lacking and insufficient to establish that medical evaluations effectively prevent material impairment caused by wearing an FFR or a loose fitting PAPR.

A standard is technologically feasible if the protective measures it requires already exist, can be brought into existence with available technology, or can be created with technology that is reasonably expected to be developed (*see Am. Iron and Steel Inst.* v. *OSHA,* 939 F.2d 975, 980 (D.C. Cir. 1991)). Courts have also interpreted technological feasibility to mean that a typical firm in each affected industry or application group will reasonably be able to implement the requirements of the standard in most operations most of the time (*see, e.g., Pub. Citizen* v. *OSHA,* 557 F.3d 165, 170–71 (3d Cir. 2009) (citing *United Steelworkers of Am.,* 647 F.2d 1189, 1272).

OSHA has determined that this proposed rule does not impose any new feasibility burdens on employers. All employers in compliance with the existing standard will also be in compliance with the proposed revisions. This proposed rule simply removes some requirements for the use of medical evaluations for loose-fitting PAPRs and FFRs. Therefore, OSHA has determined that the proposed changes to 29 CFR 1910.134 are technologically feasible.

In determining economic feasibility, OSHA must consider the cost of compliance in an industry rather than on individual employers. In its economic analyses, OSHA ''must construct a reasonable estimate of compliance costs and demonstrate a reasonable likelihood that these costs will not threaten the existence or competitive structure of an industry, even if it does portend disaster for some marginal firms'' (*Am. Iron and Steel Inst.,* 939 F.2d at 980, quoting *United Steelworkers of Am.,* 647 F.2d at 1272). OSHA has determined that this proposed rule is economically feasible because this action is deregulatory and imposes no additional costs.

The Administrative Procedures Act directs agencies to include in each rule adopted ''a concise general statement of [the rule's] basis and purpose'' (5 U.S.C. 553(c)); cf. 29 U.S.C. 655(e) (requiring the Secretary to publish a ''statement of reasons'' for any standard promulgated)). This notice satisfies this concise statement requirement.

Estimated Cost Savings From Eliminating Requirement for Medical Evaluation for Filtering Facepiece Respirators and Loose-Fitting PAPRs

OSHA estimated the potential cost savings associated with removing the medical evaluation requirement for

certain classes of respirators from CFR 1910.134 (Respiratory Protection) and potential reductions in the number of employees receiving follow-up medical exams. This required estimating the number of employees that would no longer receive the medical questionnaire for the specific type of respirators used as well as the number of employees that would no longer receive follow-up medical exams. A general description of the approach used to develop these estimates is presented below.

Annual Medical Questionnaire Cost Savings

To estimate the number of employees that would no longer receive a medical questionnaire, OSHA used data from the National Institute for Occupational Safety and Health (NIOSH) survey on Respirator Usage in Private Sector Firms for 2001 (NIOSH, 2003). This survey represents the most recent and complete dataset on respirator usage available at present. The dataset includes estimates of the number of employees using certain types of respirators by broad industry division. Based on the estimates of employees using certain types of respirators, OSHA calculated the percentage of all employees across industry groups that use these types of respirators, comparing these estimates to employment figures in the County Business Patterns (CBP) dataset for 2001. OSHA then applied these percentages to the number of employees across industry groups estimated in the CBP dataset for 2022, which represents the most recent CBP dataset available. The NIOSH survey included mining employees in its population sample. Because mining is not covered by OSHA, an adjustment was made to the total number of potentially affected employees by subtracting employees within the Mining, Quarrying, and Oil and Gas Extraction sector (NAICS 21) that are outside of the following industries:

1—Crude Petroleum Extraction (NAICS 211120)
2—Natural Gas Extraction (NAICS 211130)
3—Drilling Oil and Gas Wells (NAICS 213111)
4—Support Activities for Oil and Gas Operations (NAICS 213112)

One final adjustment that OSHA made for this analysis is to account for the specific type of respirator that employees use. Only those employees using either a filtering facepiece respirator (FFR) or loose-fitting powered air purifying respirator (PAPR) will no longer have to complete a medical questionnaire or receive a medical evaluation. According to the 2022 County Business Patterns survey, there were approximately 136 million employees in the private sector. The NIOSH respirator survey found that about 1.939 percent of employees wore filtering facepieces, indicating that, assuming the profile remained the same, approximately 2.6 million employees wear filtering facepieces currently. Another 0.098 percent reported using loose-fitting PAPRs, which accounts for an additional 133,266 workers. These groups together would total 2.038 percent of employees, or 2,733,069 employees in private industry who currently use either an FFR or loose-fitting PAPR in their work. The spreadsheet detailing these calculations is available in the rulemaking docket on *regulations.gov* (Docket No. OSHA–2025–0006).

Since the medical questionnaire is only required for new employees, OSHA estimates the number of questionnaires that are no longer required by multiplying the number of covered employees in non-mining private industry that use either an FFR or loose-fitting PAPR in the course of their work by the Bureau of Labor Statistics' (BLS') Job Openings and Labor Turnover Survey (JOLTS) annual total separations rate (43.9 percent). This approach results in an estimated 1,199,817 questionnaires that are no longer required annually.

The medical questionnaire is estimated to take an employee 15 minutes [1] on average to complete, which means that this new rule saves approximately 299,954 hours of labor time.

OSHA estimates the cost savings of this proposed rule using BLS' Occupational Employment and Wage Statistics data. Specifically, OSHA pulled the cross-industry median hourly wage for all occupations ($23.80) and calculated the loaded hourly wage to account for fringe benefits. According to BLS' Employer Costs for Employee Compensation (ECEC) data for December 2024, the fringe rate was 31.1 percent. OSHA also accounts for indirect expenses that cannot be tied to producing a specific product or service, called overhead costs. OSHA used an overhead rate of 17 percent of base wages (EPA, 2002; Rice, 2002). This 17 percent rate is based on an estimate of overhead costs for safety and health professionals in large private organizations. A rate of 17 percent of base wages is equivalent to 11.71 percent of the hourly wage rate with fringe applied. To calculate the fully loaded hourly labor cost, OSHA added the three components together: base wages + fringe benefits (31.1 percent of total compensation) + applicable overhead (17 percent of base wages). OSHA estimates a fully loaded wage of $38.59. Multiplying this wage by the total number of labor hours saved (approximately 299,954) results in total annual cost savings of $11,575,237. The total cost savings over a 10-year time period would equal roughly $115.8 million. The present value of these cost savings using a 3 and 7 percent discount rate would equal $98.7 and $81.3 million, respectively.

Annual Follow-Up Medical Exam Cost Savings

OSHA has previously estimated that 23 percent of all questionnaire recipients receive follow-up medical exams under the requirements of this standard.[2] OSHA estimates that, with the medical questionnaire no longer required, paralleling the earlier preamble discussion, only about 2 percent of the original questionnaire recipients would still receive follow-up medical exams (see Section I.B., Health Literature Background). These employees are expected to be referred for medical exams after undergoing training as required under paragraph (k) of the existing respiratory protection standard.

Using these estimates, OSHA calculated cost savings associated with medical exams no longer performed. OSHA multiplied the difference in pre- and post-standard revision required exams outlined above (21 percent) by the number of questionnaires estimated in Section 1 (1,199,817), which yields 251,962 employees that would no longer receive follow-up medical exams. The follow-up medical exams are estimated to take one hour to complete.[3] Therefore, a total of 251,962 burden hours are avoided. Using a fully loaded worker wage of $38.59 (derived previously), the total annual labor-based cost savings associated with medical exams equals $9,723,199.

OSHA also estimated the cost savings associated with not administering the medical exam itself. Using price data

[1] This estimate of workers' time was used most recently in OSHA's estimates of cost of a respirator program in the COVID ETS rulemaking. See Document ID OSHA–2020–0004–1031. Arguably, a complementary amount of time would be required by the a PLHCP to review the questionnaire, but this cost may overlap with that already included in the cost of the exam. For simplicity this element has been left out of the calculation and therefore may be an underestimate.

[2] See the Supporting Statement for the PRA Information Collection Request (ICR) for 29 CFR 1910.134, Document ID OSHA–2011–0027–0020.

[3] *Id.*

from the Centers for Medicare & Medicaid Services (CMS) (*https://www.cms.gov/medicare/physician-fee-schedule/search*), OSHA estimates that these follow-up medical exams cost $193.75 each.[4] Multiplying this unit cost by the number of medical exams previously estimated (251,962), OSHA calculates an additional $48,817,566 in annual cost savings.

In total, OSHA estimates annual medical exam cost savings of $58,540,765.

Annual Recordkeeping Cost Savings

This proposed regulatory revision also impacts the cost to maintain medical records and provide employees access to these records upon request. OSHA estimates that there are 1,199,817 medical questionnaires and 251,962 follow-up medical exams that will no longer be required and thus will also no longer have records maintained. OSHA has previously estimated that each medical record takes a secretary five minutes on average to record in their entity's recordkeeping system.[5] Therefore, this recordkeeping task is estimated to take secretaries a total of 120,982 hours annually. OSHA also has estimated that 10 percent of employees will request their medical records, with each request requiring five minutes of secretarial time to process and deliver medical records to the requesting employee, totaling 12,098 hours of total burden time.[6]

In aggregate, this regulatory revision is expected to save 133,080 burden hours of annual recordkeeping activities. Using a fully loaded wage for secretaries (SOC 43–6010) (based on BLS' Occupational Employment and Wage Statistics) of $37.00 yields $4.9 million in annual cost savings, with a present value using both 3 and 7 percent discount rates equaling $42.0 and $34.6 million, respectively.

Questionnaire Cost Savings if Baseline Compliance Were To Increase

As part of this regulatory revision, OSHA also accounts for employees that have not yet received medical questionnaires that should have in the absence of this regulatory revision. The resulting effects will be presented as though they occur in a concentrated period of time; however, there is uncertainty about whether the existing non-compliance would ever be addressed, and even if so, the timing is even more hypothetical.

OSHA calculated the number of employees that have not yet received medical questionnaires by first subtracting the number of Mining, Quarrying, and Oil and Gas Extraction sector employees using FFRs from the total projected number of employees using these respirators using the same methodology as outlined in Section 1 (2,599,807 employees). (Note that this does not include those employees wearing loose-fitting PAPRs (133,262).) Next, OSHA assumed that 30 percent of these employees started wearing respirators during the COVID–19 pandemic but were never properly evaluated during this period. As a result, OSHA estimates that, in the absence of this regulatory revision, there are 779,942 employees that would still need to receive the medical questionnaire. Assuming the same 15 minutes of burden time per medical questionnaire used in Section 1, OSHA calculates total burden savings of 194,986 hours of workers' time. OSHA multiplied this burden savings estimate by the fully loaded worker wage ($38.59; derived previously) to estimate cost savings of $7,524,491. Annualizing this savings over 10 years using 3 and 7 percent discount rates equals $882,100 and $1,071,318, respectively.

Medical Exam Cost Savings if Baseline Compliance Were To Increase

OSHA assumes that 23 percent of the employees that have not received a medical questionnaire identified in Section 4 will also not receive follow-up medical exams and does not require a further adjustment from 23 percent to 2 percent as was done in Section 2. Therefore, OSHA estimates that 179,387 current employees will not receive a follow-up medical exam given this regulatory revision. Given an assumed one hour to complete these follow-up medical exams, OSHA estimates an additional 179,387 hours of burden time saved by this regulatory revision. Using a fully loaded worker wage of $38.59, the one-time labor-based cost savings associated with these medical exams equals $6,922,532. Again, using the CMS-based unit cost for medical exams ($193.75), cost savings from the medical exams themselves equals $34,756,170. Total one-time medical exam cost savings equal $41,678,702. Annualizing these savings over 10 years using 3 and 7 percent discount rates equals $4,886,015 and $5,934,109, respectively.

Recordkeeping Cost Savings if Baseline Compliance Were To Increase

OSHA also considers cost savings associated with the medical records for those employees who should have but who did not receive a medical questionnaire or follow-up exam under the existing standard, for whom medical records will not be recorded and maintained due to this proposed revision. OSHA estimates that a total of 959,329 medical records (779,942 medical questionnaires and 179,387 follow-up medical exams) will no longer be needed to comply with this standard. OSHA assumes each medical record would have taken five minutes to record in recordkeeping systems. OSHA also assumes that 10 percent of employees would have requested access to these medical records, taking an additional five minutes per records request. These recordkeeping tasks are estimated to take 87,936 burden hours in total. Using a secretary's fully loaded wage of $37.00, OSHA estimates one-time recordkeeping cost savings of $3,253,723. Using discount rates of 3 and 7 percent and a time period of ten years, annualized cost savings equal $381,436 and $463,257, respectively.

Total Cost Savings

Table 1 shows the total annualized cost savings associated with regulatory revisions to this standard.

TABLE 1—TOTAL COST SAVINGS FROM RESPIRATORY PROTECTION STANDARD REVISIONS

Item	One-time cost savings *	Annual cost savings	Annualized one-time cost savings		Total annualized cost savings	
			3%	7%	3%	7%
Questionnaires	$7,524,491	$11,575,237	$882,100	$1,071,318	$12,457,337	$12,646,556
Medical Exams	41,678,702	58,540,765	4,886,015	5,934,109	63,426,781	64,474,875

[4] This estimate uses the costs for an office visit (HCPCS 99203), spirometry (94010), chest x-ray (71048), and EKG (93000).

[5] See the Supporting Statement for the PRA Information Collection Request (ICR) for 29 CFR 1910.134, Document ID OSHA–2011–0027–0020.

[6] *Id.*

TABLE 1—TOTAL COST SAVINGS FROM RESPIRATORY PROTECTION STANDARD REVISIONS—Continued

Item	One-time cost savings *	Annual cost savings	Annualized one-time cost savings		Total annualized cost savings	
			3%	7%	3%	7%
Recordkeeping	3,253,723	4,923,950	381,436	463,257	5,305,386	5,387,207
Total	52,456,917	75,039,953	6,149,551	7,468,685	81,189,504	82,508,638

* The underlying assumption for these estimates is that, in the absence of the proposed rule, existing non-compliance would be addressed in a concentrated period of time. However, there is substantial uncertainty about the accrual of these savings and, if such accrual occurs, about the timing.

Source: OSHA DSG Office of Regulatory Analysis.

As indicated in Table 1, OSHA estimates the annualized cost savings would be approximately $81 million at a 3 percent discount rate, or $83 million at a 7 percent discount rate. The agency further estimates that the present value of those savings over the next 10 years would be $693 million at a 3 percent discount rate, or $704 million at a 7 percent discount rate. The agency has estimated these cost savings will be spread across 131,089 firms, of which 127,351 are considered ''small'' by the Small Business Administration.

Uncertainties and Request for Comment

The agency recognizes there is uncertainty in several areas in this calculation. One is the estimate of current respirator usage, which relies heavily on as a baseline from NIOSH's 2001 respirator survey, adjusted for growth in employment.[7] The agency has reasonable grounds for believing that the use of FFRs has likely increased in the interim, in part because of their common usage during the COVID–19 pandemic. If this is the case, the cost savings from this regulatory change could potentially be larger.

Another source of uncertainty is the percentage of potential respirator wearers who are referred for medical exams currently, based on their answers to the questionnaire. A long-standing assumption, used in the agency's Information Collection Requests, based on earlier information originally used in its 1998 rulemaking, indicated that 23 percent of users of all respirator types would be referred for further medical evaluation based on the questionnaire. But given both the low rates of employees being placed on restrictions for respirator use, and the relatively modest physiological demands of the type of respirators in question, suggests the percentage may be much smaller for this subgroup of respirator wearers (*i.e.,* those using FFRs and loose-fitting PAPRs).

A third potential factor of uncertainty is the assumption that all employees newly hired will need to receive a new medical assessment for their fitness to wear a respirator. This may have been a useful assumption initially for establishing the economic feasibility of the Respiratory Protection rule in 1998 and the agency believes that frequently employers will err on the side of caution. However, under some circumstances an employer may rely on the written medical evaluation from a prior employer's PLHCP if the work conditions and type and weight of the respirator remains the same (see Section IX.E of OSHA's Respiratory Protection Directive, CPL 02–00–158 (June 26, 2014), but OSHA lacks information on how often that might occur so cannot account for this possibility in these estimates.

These various sources of uncertainty will offset each other to some degree, and there are no doubt other parts of this cost-savings calculation that could be modified based on new information. The agency welcomes comment on the various assumptions and data sources used for this calculation.

B. Additional Requirements

i. OMB Review Under the Paperwork Reduction Act of 1995

The Paperwork Reduction Act of 1995 (''PRA'') defines ''collection of information'' to mean ''the obtaining, causing to be obtained, soliciting, or requiring the disclosure to third parties or the public, of facts or opinions by or for an agency, regardless of form or format'' (44 U.S.C. 3502(3)(A)). Under the PRA, a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA and the agency displays a currently valid OMB control number (44 U.S.C. 3507). Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number (44 U.S.C. 3512(a)(1)). The process for OMB approval is found in 5 CFR part 1320. This proposed rule would impose no new information collection requirements. Because the revisions would affect only minor changes to the existing information collections in 29 CFR 1910.134 (OMB Control Number 1218–0099), OMB has waived the requirements of 5 CFR part 1320 pursuant to 5 CFR 1320.18(d).

ii. State Plans

Under section 18 of the OSH Act, 29 U.S.C. 651 *et seq.,* Congress expressly provides that States may adopt, with Federal approval, a plan for the development and enforcement of occupational safety and health standards that are ''at least as effective'' as the Federal standards in providing safe and healthful employment and places of employment (29 U.S.C. 667). OSHA refers to these OSHA-approved, State-administered occupational safety and health programs as ''State Plans.'' [1]

When federal OSHA promulgates a new standard or a more stringent amendment to an existing standard, State Plans must either amend their standards to be identical to, or ''at least as effective as'' the new Federal standard or amendment, or show that an existing State Plan standard covering this issue is ''at least as effective'' as the new Federal standard or amendment (29 CFR 1953.5(a)). However, when OSHA promulgates a new standard or amendment that does not impose additional or more stringent requirements than an existing standard, State Plans do not have to amend their standards, although they may opt to do so. OSHA has preliminarily determined this proposed rule does not impose additional or more stringent requirements than the existing standard, and therefore State Plans are not required to amend their standards. OSHA seeks comment on this assessment of its proposal.

[7] In 2023, NIOSH was commissioned to develop and administer and updated respirator usage survey. That effort is still underway and the results are not available at this time.

iii. Environmental Impacts/National Environmental Policy Act (NEPA)

OSHA has reviewed the proposed rule according to the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321 *et seq.*), as amended by the Fiscal Responsibility Act of 2023 (Pub. L. 118–5, 321, 137 Stat. 10), and the Department of Labor's NEPA procedures (29 CFR part 11). OSHA has preliminarily determined that this proposal would have no impact on the quality of the human environment.

iv. Other Statutory and Executive Order Considerations

OSHA has examined this proposed rule and has determined that it is consistent with the policies and directives outlined in E.O. 14192, ''Unleashing Prosperity Through Deregulation.'' This proposed rule is expected to be an Executive Order 14192 deregulatory action.

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) requires preparation of an initial regulatory flexibility analysis (IRFA) and a final regulatory flexibility analysis (FRFA) for any rule that by law must be proposed for public comment, unless the agency certifies that the rule, if promulgated, will not have a significant economic impact on a substantial number of small entities. OSHA reviewed this proposed rule under the provisions of the Regulatory Flexibility Act. This rule would eliminate burdensome regulations. Therefore, OSHA certifies that the rescission would not have a ''significant economic impact on a substantial number of small entities,'' and that the preparation of an IRFA is not required. OSHA will transmit this certification and supporting statement of factual basis to the Chief Counsel for Advocacy of the Small Business Administration for review under 5 U.S.C. 605(b).

Executive Order (E.O.) 12866, ''Regulatory Planning and Review,'' 58 FR 51735 (Oct. 4, 1993), requires agencies, to the extent permitted by law, to (1) propose or adopt a regulation only upon a reasoned determination that its benefits justify its costs (recognizing that some benefits and costs are difficult to quantify); (2) tailor regulations to impose the least burden on society, consistent with obtaining regulatory objectives, taking into account, among other things, and to the extent practicable, the costs of cumulative regulations; (3) select, in choosing among alternative regulatory approaches, those approaches that maximize net benefits; (4) to the extent feasible, specify performance objectives, rather than specifying the behavior or manner of compliance that regulated entities must adopt; and (5) identify and assess available alternatives to direct regulation, including providing economic incentives to encourage the desired behavior, such as user fees or marketable permits, or providing information upon which choices can be made by the public.

Section 6(a) of E.O. 12866 also requires agencies to submit ''significant regulatory actions'' to OIRA for review. OIRA has determined that this proposed rule is a ''significant regulatory action'' under the criteria in section 3(f)(4) of E.O. 12866. Accordingly, this proposed rule was submitted to OIRA for review under E.O. 12866.[8]

OSHA has considered its obligations under the Unfunded Mandates Reform Act (UMRA) (2 U.S.C. 1501 *et seq.*), and the Executive Orders on Consultation and Coordination With Indian Tribal Governments (E.O. 13175, 65 FR 67249 (Nov. 6, 2000)), Federalism (E.O. 13132, 64 FR 43255 (Aug. 10, 1999)), and Protection of Children From Environmental Health Risks and Safety Risks (E.O. 13045, 62 FR 19885 (Apr. 23, 1997)). Given that this is a proposed deregulatory action that involves the removal of medical evaluation requirements for employees required to use PAPRs and FFRs, that OSHA does not foresee economic impacts of $100 million or more, and that the action does not constitute a policy that has federalism or tribal implications, OSHA has determined that no further agency action or analysis is required to comply with these statutes and executive orders.

C. Summary and Explanation of the Proposed Rule

In this NPRM, OSHA proposes to remove medical evaluation requirements for employees required to use filtering facepiece respirators (FFRs) or loose-fitting powered air-purifying respirators (PAPRs), as specified in paragraph (e). As defined in paragraph (b), a *filtering facepiece respirator* means a negative pressure particulate respirator with a filter as an integral part of the facepiece or with the entire facepiece composed of the filtering medium. Paragraph (b) also defines *loose-fitting* to mean a respiratory inlet covering that is designed to form a partial seal with the face and *powered air-purifying respirator* to mean an air-purifying respirator that uses a blower to force the ambient air through air-purifying elements to the inlet covering. OSHA proposes that the initial medical evaluation requirements would only be removed for FFRs and loose fitting PAPRs and the medical evaluation requirements for any other air-purifying or supplied-air respirator would not be impacted and still apply. All other required provisions under the Respiratory Protection Standard (29 CFR 1910.134), including the hazard assessment; selection of respiratory protection equipment; fit testing; training and education; and maintenance and care continue to apply under this proposal. OSHA anticipates that this approach will allow employers to focus medical evaluations on employees for whom those evaluations are likely to be beneficial.

Currently, paragraph (e)(1) requires the medical evaluation of employees required to wear a respirator and a determination that those employees are able to use the respirators selected by the employer. Medical evaluation of employees prior to respirator use avoids exposing employees to the physiological stresses associated with such use. In the 1998 final rule revising the Respiratory Protection Standard (63 FR 1152), OSHA found that adverse health effects can result, in some cases, even from short duration use of respirators. Through extensive literature review, the agency previously concluded there is a potential for adverse health effects resulting from respirator use, even for healthy employees using respirators designed for low breathing resistance and used for short durations. As such, the agency determined that respirator use would impose a substantial risk of material impairment to the health of employees who have preexisting respiratory and cardiovascular impairments.

The proposed revision to the standard, as noted above, provides an exception for employees who use FFRs or loose-fitting PAPRs from the requirement that employers must medically evaluate employees required to wear a respirator. OSHA believes these revisions are appropriate due to the lack of data illustrating material impairment from wearing FFRs and loose-fitting PAPRs and the lack of data demonstrating that medical evaluations effectively predict adverse outcomes for workers wearing FFRs and loose-fitting PAPRs, as discussed in the *Health Literature Background* (Section IB. of this preamble). This lack of data is combined with widespread usage of FFRs and loose fitting PAPRs, especially in the wake of the COVID–19 pandemic. Ultimately, the agency preliminarily concludes that a finding that medical evaluations prevent adverse outcomes

[8] OIRA has determined that this proposed rule is not an economically significant regulatory action under section 3(f)(1) of E.O. 12866.

from the occupational use of FFRs and loose-fitting PAPRs is unwarranted. While the agency does not question the need for medical evaluations for other types of respirators, the literature does not support their efficacy when using FFRs and loose-fitting PAPRs in environments that are not immediately dangerous to life or health. As such, proposed paragraph (e)(1)(ii) exempts employees required to use FFRs or loose-fitting PAPRs from the requirements of paragraph (e). The agency seeks comments on all aspects of this proposed change, including the submission of information and data on the efficacy of medical evaluations preventing adverse health outcomes when using FFRs or loose-fitting PAPRs. OSHA also seeks comment on voluntary respirator use, specifically if there are any concerns with the voluntary use of FFRs and loose-fitting PAPRs and the actions of this NPRM.

Paragraph(s) (e)(2) through (e)(7) would not be impacted by the proposed exemption in paragraph (e)(1) for FFRs and loose-fitting PAPRs. If medical evaluation is required under paragraph (e)(1), the employer must comply with all requirements of paragraph (e). OSHA seeks comment on whether paragraph (e)(7) should remain applicable to FFR and loose-fitting PAPR use and require the employer to provide medical evaluations whenever symptoms arise that may be related to this use as well as any information or data on the current frequency of medical reevaluations as required by paragraph (e)(7).

OSHA recognizes that adopting these revisions will also result in the revision of the respiratory protection requirements in OSHA's construction and maritime industry standards, which apply the requirements in 29 CFR 1910.134 to construction and maritime work. (*See* 29 CFR 1926.103 (construction); 29 CFR 1915.154, 29 CFR 1917.92, and 29 CFR 1918.102 (maritime)). OSHA is in the process of appointing members to the Advisory Committee on Construction Safety and Health (ACCSH). The agency intends to present this proposed rule to ACCSH once that process is complete. The agency will put the Committee's recommendations on the OSHA website and in the docket for this proposed rule prior to the close of the comment period to allow the public to provide comments on those recommendations.

III. Authority and Signature

Amanda Laihow, Acting Assistant Secretary of Labor for Occupational Safety and Health, authorized the preparation of this document under the authority granted by sections 4 and 6 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 653, 655, 657); section 107 of the Contract Work Hours and Safety Standards Act (the Construction Safety Act) (40 U.S.C. 3704); section 41 of the Longshore and Harbor Worker's Compensation Act (33 U.S.C. 941); 5 U.S.C. 553, Secretary of Labor's Order No. 8–2020 (85 FR 58393), and 29 CFR part 1911.

Signed at Washington, DC, on June 26, 2025.

Amanda Laihow,

Acting Assistant Secretary of Labor for Occupational Safety and Health.

List of Subjects in 29 CFR 1910

Health, Occupational safety and health, Respirators, Respirator selection.

IV. Proposed Regulatory Text

Amendments

For the reasons set forth in the preamble, OSHA is proposing to amend 29 CFR part 1910 as follows:

PART 1910—OCCUPATIONAL SAFETY AND HEALTH STANDARDS

■ 1. The authority citation for part 1910 continues to read:

Authority: 33 U.S.C. 941; 29 U.S.C. 653, 655, 657; Secretary of Labor's Order No. 12–71 (36 FR 8754); 8–76 (41 FR 25059), 9–83 (48 FR 35736), 1–90 (55 FR 9033), 6–96 (62 FR 111), 3–2000 (65 FR 50017), 5–2002 (67 FR 65008), 5–2007 (72 FR 31160), 4–2010 (75 FR 55355), 1–2012 (77 FR 3912), or 08–2020 (85 FR 58393); 29 CFR part 1911; and 5 U.S.C. 553, as applicable.

Subpart I—Personal Protective Equipment.

■ 2. Amend § 1910.134 by revising paragraph (e)(1) to read as follows:

§ 1910.134 Respiratory Protection.

* * * * *

(e) * * *

(1) *General.* (i) Except as otherwise provided in this paragraph, the employer shall provide a medical evaluation to determine the employee's ability to use a respirator, before the employee is fit tested or required to use the respirator in the workplace. The employer may discontinue an employee's medical evaluations when the employee is no longer required to use a respirator.

(ii) The medical evaluation requirements of this paragraph do not apply to the following:

(A) The required use of filtering facepiece respirators.

(B) The required use of loose-fitting powered air-purifying respirators.

* * * * *

[FR Doc. 2025–12235 Filed 6–30–25; 8:45 am]

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DEPARTMENT OF LABOR

41 CFR Parts 60–1, 60–2, 60–3, 60–4, 60–20, 60–30, 60–40, 60–50 and 60–999

[Docket No. OFCCP–2025–0001]

RIN 1250–AA17

Rescission of Executive Order 11246 Implementing Regulations

AGENCY: Office of Federal Contract Compliance Programs, Labor.

ACTION: Proposed rule; request for comments.

SUMMARY: The U.S. Department of Labor (DOL) proposes to rescind the regulations for Executive Order (E.O.) 11246, as amended. E.O. 11246 was revoked by E.O. 14173 on January 21, 2025. The E.O. 11246 regulations prohibited covered Federal contractors and subcontractors from discriminating in employment based on race, color, religion, sex, sexual orientation, gender identity, and national origin and required them to take affirmative action on those bases. They also prohibited these employers from taking adverse employment actions against applicants or employees because they inquired about, discussed, or disclosed information about their pay or their co-workers' pay, subject to certain limitations.

DATES: Comments must be received by September 2, 2025.

ADDRESSES: Comments must be submitted in one of the following two ways (please choose only one of the ways listed):

- Electronically at *https://www.regulations.gov.* Follow the ''Submit a comment'' instructions. If you are reading this document on *federalregister.gov*, you may use the green ''SUBMIT A PUBLIC COMMENT'' button beneath this rulemaking's title to submit a comment to the *regulations.gov* docket.
- You may mail written comments to the following address: Catherine L. Eschbach, Director, Office of Federal Contract Compliance Programs, 200 Constitution Avenue NW, Washington, DC 20210. Mailed comments must be received by the close of the comment period.

Do not include any personally identifiable information (such as name, address, or other contact information) or