



Preparing your outpatient facility for a pandemic

Hospitals may be the focus for a serious pandemic, but a mild virus could flood outpatient facilities

Each year, medical facilities around the country use the months leading up to annual flu season to prepare for the possibility of an influenza pandemic.

But never before have these preparations been so real and urgent. Technically, the world is in the midst of a pandemic, as declared by the World Health Organization, but the threat of a severe pandemic that would flood the nation's healthcare system has rarely been so imminent.

Unfortunately, many medical facilities are finding that it's difficult to prepare for something that is so unpredictable and that even medical experts know so little about. Although the influenza A H1N1 outbreaks in the spring were relatively mild, there is no guarantee the same virus, coupled with seasonal flu, won't come back with more serious consequences.

From the perspective of an outpatient facility, a mild

case of H1N1 this winter could actually mean a strong surge for outpatient facilities and physician offices, says Paul Biddinger, MD, medical director for emergency preparedness and emergency physician at Massachusetts General Hospital in Boston and chair of the Massachusetts Medical Society's Committee on Preparedness.

"I think the biggest unknown is not even so much how people will react, but how the virus is going to unfold," Biddinger says. "In previous pandemics, there has been a second wave with significant illness. Sometimes that illness has been more mild; sometimes it has been more severe, like 1918. If the second wave of H1N1 causes mostly mild illness, I think outpatient providers will feel the brunt of the surge of patients. If the virus causes more severe illness, it may be more in

the emergency department and in the hospital setting."

Regardless of severity, outpatient facilities should prepare, just as hospitals do, for a surge of patients, a potential shortage of employees, and ways to reduce transmission of the disease within the facility.

To assist smaller medical facilities, the CDC has released 10 steps that medical offices and outpatient facilities can take to prepare for the upcoming flu season. Below we touch on some of the most important areas.

Keep your facility operational

During a pandemic, there is a high likelihood that staff members will not report to work for a variety of reasons. Some may contract the virus, others may have children or family members > p. 2

INSIDE THIS ISSUE:

- ▶ OSH 1-5
- ▶ Self-inspection notes 6
- ▶ For your information 7
- ▶ Questions & answers 8

OSHA stat: \$3,367

This amount was the average initial fine imposed on physician practices from July 1, 2008, to June 30, 2009, for not having an exposure control plan that includes procedures for the evaluation of circumstances surrounding exposure incidents, per 1910.1030(c)(1)(ii)(c).

Although this was the most expensive category of fines, other violations were nearly as costly and more frequent.

This issue of **Medical Environment Update** contains the OSHA bloodborne pathogens violation report for physician practices on p. 5. The report covers both severe monetary penalties and frequent bloodborne pathogens violations.

Occupational safety and health *continued*

Pandemic *cont. from p. 1*

to care for, and others may require time off because of school closures.

Healthcare worker absenteeism can be detrimental to any facility, but for a small facility with few employees, it can be crippling. Unfortunately, absenteeism is also the toughest to plan for, says **Terri Rebmann, PhD, RN, CIC**, associate director

for curricular affairs and assistant professor at the Institute for Biosecurity at Saint Louis University School of Public Health.

"The main thing is they should be talking about it now and trying to make some kind of plan, knowing there are going to be staff shortages," Rebmann says. "We already saw that before it was even deemed a pandemic, there were staffing shortages."

Rebmann suggests hiring contract workers or even retired healthcare professionals or medical students if the pandemic is bad enough.

Keep in mind that during a pandemic, healthcare workers that exhibit symptoms of influenza should remain at home. Rebmann says a big contributor to the SARS outbreak in 2003 was the fact that sick healthcare workers were still coming to work.

"[Healthcare facilities] need to be looking at their occupational health and sick leave policies to really make sure staff are able to call in sick with no repercussions," Rebmann says.

Biddinger says some facilities allow their employees to take workers' compensation

if they develop influenza-like symptoms and have been caring for flu patients, but only if they have received the seasonal flu vaccine.

"The idea is that you start letting people take workers' comp and avoid using their personal or sick time, and also it's hopefully an added incentive to get the seasonal flu vaccine because you are alerting employees they will have to take personal time if they elect not to get vaccinated," says Biddinger.

Most importantly, the finalized policies need to be clearly stated and understood by all staff members.

Plan for a surge of patients

Regardless of whether your facility will be hit hard by seasonal influenza or the H1N1 virus, even small medical facilities should have a detailed plan in place to handle a sudden or prolonged surge of patients.

Rebmann conducted a focus group on the H1N1 outbreaks among infection preventionists at the June Association for Professionals in Infection Control conference. Many of the pediatric facilities reported that their 24/7

Medical Environment Update

(ISSN: 1520-8222 [print]; 1934-5453 [online])

Published 12 times per year by

HPro, Inc.

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Single issues available from the publisher.
Multiple subscription rates available.

12 issues: \$179 • 24 issues: \$322

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We are Twittering



Yes, **Medical Environment Update** is now on Twitter. Look for it at http://twitter.com/OSHA_Healthcare to see what we are covering—and sometimes previewing for future reports—in 140-character updates.

Still in the dark about Twitter? Search for the Twitter post on **OSHA Healthcare Advisor** at www.oshahealthcareadvisor.com for how this social media network might be useful to your OSHA compliance duties. **BLOG**

Occupational safety and health continued

hotline worked well to triage patients or provide care without bringing them into the facility.

“That at least reduced the number of people that would show up in the ED, because families would call in, talk to a health-care provider on the phone, and decide ‘yes, it’s an emergency; I should go in,’ or ‘no, it’s probably not; I can go see my physician or I can just stay home and not even require treatment,’” says Rebmann.

Biddinger agrees that a phone system reduces the number of sick patients and worried well entering a facility. However, establishing this phone system is often cumbersome for smaller facilities with fewer resources. Biddinger suggests directing patients to their local or state health department’s phone line, which should be in place for providing guidance or answering questions.

Other facilities that are part of a system may want to consider pooling their resources and placing one or two nurses on call for the entire system.

“Assuming the illness stays relatively mild as it has been so far, a good number of patients can be treated at home without ever having to see a physician or take up an office spot,” Biddinger says.

Screen patients for symptoms at the door

Many experts say the most important part of reducing the transmission of seasonal influenza

and H1N1 is separating sick patients from well patients as soon as they enter the facility. To accomplish this requires two

things: screening procedures and isolation precautions.

Rebmann notes that isolation precautions, especially > p. 4

What kind of PPE should I wear?

An ongoing debate has come to the forefront of pandemic preparedness as medical facilities plan to protect workers from seasonal influenza and the H1N1 virus.

The Society for Healthcare Epidemiology of America (SHEA) has already released recommendations that healthcare workers use droplet precautions and wear surgical masks, rather than airborne precautions, which require N95 respirators.

The CDC’s Healthcare Infection Control Practices Advisory Committee (HICPAC) has adopted those same recommendations, according to a July 23 report by the Association for Professionals in Infection Control (APIC). However, the CDC is not required to automatically accept HICPAC’s recommendations and has yet to change the interim guidelines.

Paul Biddinger, MD, medical director for emergency preparedness and emergency physician at Massachusetts General Hospital in Boston and chair of the Massachusetts Medical Society’s Committee on Preparedness, says surgical masks should be adequate protection against seasonal flu and H1N1.

“As far as we know, this H1N1 influenza is transmitted the same as seasonal influenza, which is by the droplet route,” Biddinger says. “Therefore, keeping people 3 ft. away from one another; wearing a simple surgical mask instead of an N95; and good hand hygiene, gloves, and gown are the basic droplet precautions, and those protect the staff. I think there has been a lot of concern in the medical community that they aren’t getting appropriate [personal protective equipment (PPE)], meaning they aren’t getting N95s, when in actuality they don’t really need it.”

Acquiring the proper PPE will be a challenge, especially for outpatient facilities, since most reserves will go to large hospitals with higher risk, says **Terri Rebmann, PhD, RN, CIC**, associate director for curricular affairs and assistant professor at the Institute for Biosecurity at Saint Louis University School of Public Health. Therefore, Rebmann recommends consulting the respiratory protection guidance documents published by the Institute of Medicine for putting a surgical mask over an N95 respirator to help durability, as well as the APIC guidelines for reuse of N95 respirators.

“I would think outpatient facilities would really need that kind of guidance because they are probably not going to be able to use what would typically be a single-use respirator only one time,” Rebmann says. “They are going to have to find other ways to reuse that respirator.”

This debate has been a source of confusion for pandemic planning committees and healthcare workers, but ultimately, the employer will be held to state and federal OSHA standards. The best solution is to determine what protection is required by CDC guidelines and OSHA, include it in the plan, and clearly explain it to your staff.

*Editor’s note: For more details, see the pandemic influenza in the Emergency and Disaster Planning section of your OSHA Regulatory Manual for Healthcare. You can also visit **OSHA Healthcare Advisor** for the most up-to-date respiratory protection guidelines from the CDC, APIC, SHEA, and OSHA. [BLOG](#)*

Occupational safety and health *continued*

Pandemic *cont. from p. 3*

those involving negative pressure, are extremely difficult in the limited space of an outpatient facility. Instead, the facility should plan on designating one or two rooms to place patients with influenza as soon as they enter the facility.

"Some people have talked about dividing the waiting area, almost like they do with pediatric clinics where they have a sick child area and a well child area," Rebmann says. "You could do something similar in outpatient

facilities if you have that space and the capabilities of doing that."

But to separate the sick from the well, you need to have screening measures in place. Screening techniques range from passive screening, such as placing a sign at the facility entrance that directs patients according to their symptoms, to active screening, which might include a brief medical exam.

However, actively screening patients requires resources, which is why many facilities are moving toward enlisting volunteers, student workers, or even security guards to perform basic

assessments with the help of a simple checklist.

"We aren't talking about a medical evaluation, obviously," Rebmann says. "That's going to be done by the medical providers." ■

*Editor's note: For more information on influenza pandemic preparedness, including guidance for outpatient facilities, establishing an effective means of communication throughout your health system, and a complete breakdown of the CDC guidelines for medical facilities, visit **OSHA Healthcare Advisor** at www.oshahealthcareadvisor.com. **BLOG***

Occupational health and safety news in brief

*Editor's note: For more on the following stories and links to source documents and tools, visit **OSHA Healthcare Advisor** at www.oshahealthcareadvisor.com. **BLOG***

Obama nominates new OSHA director

In a departure from previous administrations, a scientist is slated to lead OSHA with President Obama's July 28 nomination of David Michaels, PhD, MPH.

Michaels, a research professor in epidemiology and interim chair of the Department of Environmental and Occupational Health at The George Washington University School of Public Health and Health Services, is a critic of manufacturers of dangerous products

who oppose public health and environmental regulations. The president's nomination will require confirmation by the Senate.

Congress points OSHA toward ATD standard

In a report focusing on increasing OSHA's budget by \$41.5 million from 2008, the House Appropriations Committee urged the agency to develop an airborne transmissible disease (ATD) standard in 2010, similar to the one that took effect in California last month. That standard requires healthcare employers to protect workers from ATDs such as TB, SARS, measles, and pandemic flu.

In the meantime, look for OSHA to add pandemic influenza

to its list of eTools at www.osha.gov, according to a report in the July 20 *Inside OSHA*.

Award to note safety work

It's time to acknowledge the needlestick prevention hero in your organization or profession. The Sharps Injury Prevention Award is given each year to people who are making a difference in preventing needlestick injuries and bloodborne pathogen exposures.

The International Sharps Injury Prevention Society (ISIPS), which sponsors the award, is accepting nominations at www.isips.org/vote/2009nomination.html until September 30. ISIPS will announce the winners December 1. ■

Occupational safety and health continued

Bloodborne pathogens violations in physician practices

Medical Environment Update obtained a report on OSHA violations for doctors' offices and clinics from July 1, 2008, to June 30, 2009. During that time, OSHA issued 571 citations; 405 (71%) involved bloodborne pathogens violations.

The tables below show the most frequent and expensive bloodborne pathogens citations. For information on specific bloodborne pathogens fines, other standards, or other types of healthcare facilities, e-mail dlahoda@hcpro.com or call 800/650-6787.

The next issue of **Medical Environment Update** will report on frequent and expensive non-bloodborne pathogens violations.

Most frequent Bloodborne Pathogens standard violations for doctors' offices and clinics

Violation cited by section for 1910.1030	Percentage of citations for the standard	Average initial fine
(d)(2)(i) Engineering and work practice controls not used to eliminate or minimize employee exposure	10%	\$626
(c)(1)(i) Employer does not have a written exposure control plan designed to eliminate or minimize employee exposure*	8%	\$1,312
(c)(1)(iv) Exposure control plan not reviewed and updated at least annually and whenever necessary to reflect new tasks and procedures	7%	\$436
(g)(2)(i) Employee training not provided at no cost to the employee and not during working hours	5%	\$197
(c)(1)(iv)(b) Exposure control plan does not document annually consideration and implementation of appropriate commercially available and effective safer medical devices	3%	\$625

*Appears on both most frequent and most expensive list.

Most expensive (\$1,000 or more) Bloodborne Pathogens standard violations for doctors' offices and clinics

Violation cited by section for 1910.1030	Percentage of citations for the standard	Average initial fine
(c)(1)(ii)(c) Exposure control plan does not include procedure for the evaluation of circumstances surrounding exposure incidents	1%	\$3,367
(c)(1)(ii)(a) Exposure control plan does not contain exposure determination of employees	1%	\$2,160
(c)(1)(ii)(b) Exposure control plan missing schedules and methods of implementation	2%	\$1,621
(g)(2)(viii) Person conducting the training is not knowledgeable in the subject matter	Less than 1%	\$1,500
(c)(1)(i) Employer does not have a written exposure control plan designed to eliminate or minimize employee exposure*	8%	\$1,312
(f)(3)(ii)(a) Exposed employee's blood not collected as soon as feasible and tested after consent is obtained	Less than 1%	\$1,200
(c)(1)(iv)(a) Exposure control plan not reviewed and updated at least annually to reflect changes in technology that eliminate or reduce exposure to bloodborne pathogens	Less than 1%	\$1,125

*Appears on both most frequent and most expensive list.

Source: OSHA Office of Management Systems.



Self-inspection notes

Time to recheck your vaccine storage and handling procedures

Vaccine storage and handling is not usually an OSHA concern unless it involves employee safety while working with hazardous substances and preventing needlesticks.

With the emphasis on vaccines for this year's flu season, now is the time to make sure your handling and storage procedures are in line with CDC guidelines and not destroying the effectiveness of these important medications.

An estimated 17%–37% of medical offices expose vaccines to improper storage, according to the CDC. Follow the checklist below, excerpted from the CDC's Vaccine Storage and Handling Toolkit, to safely manage vaccines in your facility.



Quick self-inspection checklist: Basics of vaccine storage and handling

- Designate a primary and a backup person for handling and storing vaccines.
- Limit access to the vaccine supply.
- Maintain an accurate inventory, documenting vaccine name, number of doses received, date received, arrival condition, manufacturer, lot number, and expiration date.
- Use a refrigerator with a separate freezer door—not dormitory-style. Do not store food or drink in this refrigerator. Store vaccines in the middle of the refrigerator or freezer, not in the door.
- Stock and rotate the supply so that the newest vaccine of each type is placed behind the vaccine with the shortest expiration date. Check weekly to ensure that vaccines are in the proper position.
- Check expiration dates and use vaccines that will expire soonest. If you are unlikely to use your inventory of a vaccine that expires within 120 days, check whether it can be returned or transferred before expiration.
- Single-dose vials are meant for one-time use only. Do not open single-dose vials until you are ready to use them. Single-dose vials without their protective caps should be discarded at the end of the clinic day. Label reconstituted multidose vials with expiration dates per the manufacturer's recommendations.
- Post a sign on the refrigerator door identifying vaccines for refrigerator or freezer storage.
- Keep a certified calibrated thermometer in the refrigerator and maintain the refrigerator temperature at 35°F–46°F (2°C–8°C). Keep extra containers of water in the refrigerator to help maintain cold temperatures.
- Keep a certified calibrated thermometer in the freezer and maintain the freezer temperature at 5°F (-15°C) or colder. Keep ice packs and other ice-filled containers in the freezer to help maintain cold temperatures.
- Post a temperature log and record the refrigerator and freezer temperatures twice per day.
- File temperature logs for three years unless state statutes or rules require a longer period.
- Know who to contact if the refrigerator fails.
- Place a "do not unplug" sign next to the refrigerator's electrical outlet. Avoid using power outlets with circuit switches or outlets activated by a wall switch. Label the fuses and/or circuit breakers.
- If a refrigerator failure occurs, take the following steps:
 - Use an emergency response worksheet to document the incident. Download one at www.immunize.org/catg.d/p3051.pdf.
 - Place vaccines in adequate refrigeration.
 - Mark exposed vaccines and separate them from undamaged vaccines.
 - Note the refrigerator or freezer temperature and the room temperature. Contact the manufacturer or state health department to determine how to handle the affected vaccines.
 - Follow the manufacturer's or health department's instructions as to whether the affected vaccines can be used. If they are usable, mark the vials with the revised expiration date.
 - Do not assume that vaccines inappropriately exposed to light or excessive temperatures are unsalvagable. Return the vaccines to appropriate storage conditions and record the time they may have been exposed. Most refrigerated vaccines will remain stable at elevated temperatures for limited periods of time.
- Obtain a detailed written routine vaccine storage and handling plan and emergency vaccine retrieval and storage plan. See source below.

Source: Reprinted with permission from CDC's Vaccine Storage and Handling Toolkit (www2a.cdc.gov/vaccines/ed/shtoolkit).

FOR YOUR INFORMATION

Group advocates drug take-back

What if pharmaceutical companies took on the financial responsibility for disposal of unused medications? That is a policy recently adopted by the National Association of Counties, reports the July 30 *Waste & Recycling News*. Specifically, the association wants pharmaceutical companies to develop prescription and over-the-counter drug take-back programs without relying on government funding.

Impossible? Unlikely, you say? The association points to a similar program developed in British Columbia last year, according to the article.

CMS to fund ASC surveys

Through the American Recovery and Reinvestment Act of 2009, CMS will award \$572,250 to 12 states to conduct surveys on 125 ambulatory surgery centers (ASC)

in September. States participating in this program are Arkansas, Florida, Indiana, Kansas, Maine, Maryland, Michigan, New Jersey, North Carolina, Oregon, Utah, and Wyoming.

This is the first installment of increased regulation for ASCs. In October, CMS will provide \$9 million for all state inspections.

Plastic surgeons and hand washing

A study conducted by Thomas Jefferson University Hospital in Philadelphia indicates that a surprising number of plastic surgeons may lack awareness on proper hand hygiene.

The study, which appeared in the July / August *Archives of Facial Plastic Surgery*, found that just more than half of the 122 facial plastic surgeons surveyed knew that alcohol-based hand rubs were preferred “for killing bacteria on hands that appear unsoiled,” according to a July 31 Reuters report.

Better hygiene awareness was recorded in dealing with visibly soiled hands; for this scenario, 75% of respondents knew about soap and water as the preferred hand hygiene method.

Only 42% correctly identified instances in which hand hygiene is recommended by CDC guidelines—for example, after contact with a patient and before and after the use of examination gloves, according to the Reuters article.

But facial plastic surgeons are not the only healthcare professionals with questionable hand hygiene practices.

Generally, adherence to hand hygiene guidelines among healthcare workers is “abysmal,” lead researcher Douglas D. Leventhal told Reuters. ■

Your virtual safety officer

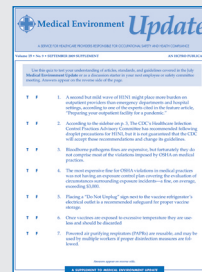
OSHA compliance assistance at your fingertips



Compliance is no place for guesswork, especially when the safety of your coworkers is at stake. David LaHoda, **Medical Environment Update** editor and OSHA expert, mans the Compliance Hotline, a key benefit for subscribers. Contact him with your difficult occupational health and safety issues by e-mail (dlahoda@hcpro.com), telephone (800/650-6787), or fax (303/926-4346).

Questions from subscribers range from how to read a material safety data sheet to what to do for an employee needlestick exposure. If LaHoda can't answer your question, he'll direct you to an appropriate resource.

September quiz inserted in this issue



Inserted in this issue is a quiz of 10 true-or-false questions. The quiz is designed to test your understanding of OSHA standards and government regulatory guidelines applying to healthcare facilities.

Use the quiz as a pre- or post-test for yourself or as a discussion starter in your next safety committee meeting or training session.

Answers are on the back side of the insert.

QUESTIONS & ANSWERS

A key benefit for subscribers to **Medical Environment Update** is access to the free OSHA Compliance Hotline. Below is a sample of the frequent or intriguing calls received in the past month. If you have an OSHA consultation question, call the hotline at 800/650-6787.

? During the swine flu outbreak, we had difficulty obtaining N95 respirators. I heard that PAPRs would be an alternative. Are they reusable?

Yes, PAPRs, or powered air purifying respirators, are reusable and sometimes are a good alternative to N95 respirators.

Not designed as a one-time use disposable item, they are much more expensive and require more maintenance than N95s, but PAPRs can be used by more than one worker.

In some healthcare settings, a few PAPRs can take the place of a storage room full of N95s. Another benefit is that you can

forego fit testing when using a PAPR.

Make sure you provide a medical evaluation for any staff member required to wear a respirator and annual training that follows the manufacturer's written instructions on disinfection, maintenance, and storage as part of your written respiratory protection plan.

For a checklist to assess your protection plan in the event of pandemic influenza, download "Scrambling for a respiratory protection plan," available from **OSHA Healthcare Advisor** at www.oshahealthcareadvisor.com. **BLOG**

? Would OSHA fine a business for worker injuries from a terrorist attack?

OSHA would not apply enforcement procedures because of the unforeseeable nature of such a workplace emergency, according to a May 25, 2004, letter of interpretation, "Application of

OSHA standards to escape and protection of employees from threats associated with terrorist actions."

The letter also explains that enforcement is only part of the agency's mandate and identifies safety preparedness resources for such an unpredictable event on the OSHA Web site, including:

- A fire and explosion planning matrix
- Health and safety plan requirements for anthrax-contaminated sites
- A fact sheet on evacuating high-rise buildings

To download copies of the documents listed above, visit OSHA's Web site at www.osha.gov/SLTC/emergencypreparedness.

Additionally, refer to the Emergency Preparedness and Disaster Plan chapter of your *OSHA Regulatory Manual for Healthcare*, which contains responses to several emergency scenarios. ■

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