2024

TLVs® and BEIs®

Based on the Documentation of the

Threshold Limit Values

for Chemical Substances and Physical Agents

&

Biological Exposure Indices

• SIGNATURE PUBLICATIONS •

POLICY STATEMENT ON THE USES OF TLVs® AND BEIs®

The Threshold Limit Values (TLVs) and Biological Exposure Indices (BEIs) are developed as guidelines to assist in the control of health hazards. These recommendations or guidelines are intended for use in the practice of industrial hygiene, to be interpreted and applied only by a person trained in this discipline. They are not developed for use as legal standards and ACGIH does not advocate their use as such. However, it is recognized that in certain circumstances individuals or organizations may wish to make use of these recommendations or guidelines as a supplement to their occupational safety and health program. ACGIH will not oppose their use in this manner, if the use of TLVs and BEIs in these instances will contribute to the overall improvement in worker protection. However, the user must recognize the constraints and limitations subject to their proper use and bear the responsibility for such use.

The introductions to the TLV/BEI Book and the TLV/BEI Documentation provide the philosophical and practical bases for the uses and limitations of the TLVs and BEIs. To extend those uses of the TLVs and BEIs to include other applications, such as use without the judgment of an industrial hygienist, application to a different population, development of new exposure/recovery time models, or new effect endpoints, stretches the reliability and even viability of the database for the TLV or BEI as evidenced by the individual Documentation.

It is not appropriate for individuals or organizations to impose on the TLVs or the BEIs their concepts of what the TLVs or BEIs should be or how they should be applied or to transfer regulatory standards requirements to the TLVs or BEIs.

Approved by the ACGIH Board of Directors on March 1, 1988.

Special Note to User

The values listed in this book are intended for use in the practice of industrial hygiene as guidelines or recommendations to assist in the control of potential workplace health hazards and for no other use. These values are *not* fine lines between safe and dangerous concentrations and *should not* be used by anyone untrained in the discipline of industrial hygiene. **It is imperative that the user of this book read the Introduction to each section and be familiar with the *Documentation* of the TLVs and BEIs before applying the recommendations contained herein.** ACGIH disclaims liability with respect to the use of the TLVs and BEIs.

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ACGIH is a 501(c)(3) charitable scientific organization that advances occupational and environmental health. The organization has contributed substantially to the development and improvement of worker health protection. The organization is a professional society, not a government agency.

The *Documentation of the Threshold Limit Values and Biological Exposure Indices* is the source publication for the TLVs® and BEIs® issued by ACGIH. That publication gives the pertinent scientific information and data with reference to literature sources that were used to base each TLV or BEI. For better understanding of the TLVs and BEIs, it is essential that the Documentation be consulted when the TLVs or BEIs are being used. For further information, contact The Science Group, ACGIH. The most up-to-date list of substances and agents under study by the committees is available at acgih.org/tlv-bei-guidelines/documentation-publications-and-data/under-study-list.

Comments, suggestions, and requests for interpretations or technical information should be directed to The Science Group at the address below or to the following e-mail address: science@acgih.org. To place an order, visit our website at acgih.org/store, contact Customer Service at the address or phone number below, or use the following e-mail address: customerservice@acgih.org.

Help ensure the continued development of TLVs and BEIs. Make a tax deductible donation to the FOHS Sustainable TLV/BEI Fund today!

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In the event significant errata are required, they will be listed on the ACGIH website at acgih.org/tlv-bei-guidelines/policies-procedures-presentations.

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STATEMENT OF POSITION REGARDING THE TLVs AND BEIs

The American Conference of Governmental Industrial Hygienists (ACGIH®) is a private, not-for-profit, nongovernmental corporation whose members are industrial hygienists or other occupational health and safety professionals dedicated to promoting health and safety within the workplace. ACGIH is a scientific association. ACGIH is not a standards-setting body. As a scientific organization, it has established committees that review the existing published, peer-reviewed scientific literature. ACGIH publishes guidelines known as Threshold Limit Values (TLVs®) and Biological Exposure Indices (BEIs®) for use by industrial hygienists in making decisions regarding safe levels of exposure to various chemical and physical agents found in the workplace. In using these guidelines, industrial hygienists are cautioned that the TLVs and BEIs are only one of multiple factors to be considered in evaluating specific workplace situations and conditions.

Each year, ACGIH publishes its TLVs and BEIs in a book. In the introduction to the book, ACGIH states that the TLVs and BEIs are guidelines to be used by professionals trained in the practice of industrial hygiene. The TLVs and BEIs are not designed to be used as standards. Nevertheless, ACGIH is aware that in certain instances the TLVs and the BEIs are used as standards by national, state, or local governments.

Governmental bodies establish public health standards based on statutory and legal frameworks that include definitions and criteria concerning the approach to be used in assessing and managing risk. In most instances, governmental bodies that set workplace health and safety standards are required to evaluate health effects, economic and technical feasibility, and the availability of acceptable methods to determine compliance.

ACGIH TLVs and BEIs are not consensus standards. Voluntary consensus standards are developed or adopted by voluntary consensus standards bodies. The consensus standards process involves canvassing the opinions, views, and positions of all interested parties and then developing a consensus position that is acceptable to these parties. While the process used to develop a TLV or BEI includes public notice and requests for all available and relevant scientific data, the TLV or BEI does not represent a consensus position that addresses all issues raised by all interested parties (e.g., issues of technical or economic feasibility). The TLVs and BEIs represent a scientific opinion based on a review of existing peer-reviewed scientific literature by committees of experts in public health and related sciences.

ACGIH TLVs and BEIs are health-based values. ACGIH TLVs and BEIs are established by committees that review existing published and peer-reviewed literature in various scientific disciplines (e.g., industrial hygiene, toxicology, occupational medicine, and epidemiology). Based on the available information, ACGIH formulates a conclusion on the level of exposure that the typical worker can experience without adverse health effects. The TLVs and BEIs represent conditions under which ACGIH believes that nearly all workers may be repeatedly exposed without adverse health effects. They are not fine

lines between safe and dangerous exposures, nor are they a relative index of toxicology. The TLVs and BEIs are not quantitative estimates of risk at different exposure levels or by different routes of exposure.

Since ACGIH TLVs and BEIs are based solely on health factors, there is no consideration given to economic or technical feasibility. Regulatory agencies should not assume that it is economically or technically feasible for an industry or employer to meet TLVs or BEIs. Similarly, although there are usually valid methods to measure workplace exposures at the TLVs and BEIs, there can be instances where such reliable test methods have not yet been validated. Obviously, such a situation can create major enforcement difficulties if a TLV or BEI was adopted as a standard.

ACGIH does not believe that TLVs and BEIs should be adopted as standards without full compliance with applicable regulatory procedures, including an analysis of other factors necessary to make appropriate risk management decisions. However, ACGIH does believe that regulatory bodies should consider TLVs or BEIs as valuable input into the risk characterization process (hazard identification, dose-response relationships, and exposure assessment). Regulatory bodies should view TLVs and BEIs as an expression of scientific opinion.

ACGIH is proud of the scientists and the many members who volunteer their time to work on the TLV and BEI Committees. These experts develop written Documentation that includes an expression of scientific opinion and a description of the basis, rationale, and limitations of the conclusions reached by ACGIH. The Documentation provides a comprehensive list and analysis of all the major published peer-reviewed studies that ACGIH relied upon in formulating its scientific opinion. Regulatory agencies dealing with hazards addressed by a TLV or BEI should obtain a copy of the full written Documentation for the TLV or BEI. Any use of a TLV or BEI in a regulatory context should include a careful evaluation of the information in the written Documentation and consideration of all other factors as required by the statutes which govern the regulatory process of the governmental body involved.

- *ACGIH is a not-for-profit scientific association.*
- *ACGIH proposes guidelines known as TLVs and BEIs for use by industrial hygienists in making decisions regarding safe levels of exposure to various hazards found in the workplace.*
- *ACGIH is not a standard-setting body.*
- *Regulatory bodies should view TLVs and BEIs as an expression of scientific opinion.*
- *TLVs and BEIs are not consensus standards.*
- *ACGIH TLVs and BEIs are based solely on health factors; there is no consideration given to economic or technical feasibility. Regulatory agencies should not assume that it is economically or technically feasible to meet established TLVs or BEIs.*
- *ACGIH believes that TLVs and BEIs should NOT be adopted as standards without an analysis of other factors necessary to make appropriate risk management decisions.*
- *TLVs and BEIs can provide valuable input into the risk characterization process. Regulatory agencies dealing with hazards addressed by a TLV or BEI should review the full written Documentation for the numerical TLV or BEI.*

ACGIH is publishing this statement in order to assist ACGIH members, government regulators, and industry groups in understanding the basis and limitations of the TLVs and BEIs when used in a regulatory context. This Statement was adopted by the ACGIH Board of Directors on March 1, 2002.

TLV/BEI DEVELOPMENT PROCESS: AN OVERVIEW

Provided below is an overview of the ACGIH TLV/BEI Development Process. Additional information is available on the ACGIH website (acgih.org). Please also refer to the attached Process Flowchart (Figure 1).

1. **Under Study:** The Under Study list will include substances or agents being actively researched or written about by the appropriate committee. Study list. Each committee determines its own selection of chemical substances or physical agents for its Under Study list. A variety of factors is used in this selection process, including prevalence, use, number of workers exposed, availability of scientific data, existence/absence of a TLV or BEI, age of TLV or BEI, input from the public, etc. The public may offer input to any TLV or BEI Committee by e-mail to science@acgih.org.

   The Under Study lists serve as notification and invitation to interested parties to submit substantive data and comments to assist the committees in their deliberations. Each committee considers only those comments and data addressing health and exposure issues, not economic or technical feasibility. Comments must be accompanied by copies of substantiating data, preferably in the form of peer-reviewed literature. Should the data be from unpublished studies, ACGIH requires written authorization from the owner of the studies granting ACGIH permission to (1) use, (2) cite within the Documentation, and (3) upon request from a third party, release the information. All three permissions must be stated/covered in the written authorization (see endnote for a sample permission statement). Electronic submission of all information to the ACGIH Science Group at science@acgih.org is preferred and greatly increases the ease and efficiency with which the committee can consider the comments or data.

   The Under Study list is published on the ACGIH website, updated continuously, and in the TLVs and BEIs book, which is current as of December 1 of the prior year.

2. **Draft Documentation:** One or more members of the appropriate committee collect information and data from the scientific literature, review results of unpublished studies submitted for review, and develop a draft TLV or BEI Documentation. The draft Documentation is a critical evaluation of the scientific literature relevant to recommending a TLV or BEI; however, it is not an exhaustive critical review of all studies but only those pertinent to identifying the critical effect and setting the TLV or BEI. Particular emphasis is given to papers that address minimal or no adverse health effect levels in exposed animals or workers that deal with the reversibility of such effects, or in the case of a BEI, that assess chemical uptake and provide applicable determinant(s) as an index of uptake. Human data, when available, are given special emphasis. This draft Documentation, with its proposed TLV or BEI, is then reviewed and critiqued by additional committee members and eventually by the full committee. This process often results in several revisions to the draft Documentation before the full committee accepts the proposed draft TLV or BEI and draft Documentation. The draft Documentation

is not available to the public during this stage of the development process and is not released until it is at the Notice of Intended Changes (NIC) stage. Authorship of the Documentation is not disclosed.

3. **Notice of Intended Changes (NIC):** When the full committee accepts the draft Documentation and its proposed TLV or BEI, the Documentation and proposed values are then recommended to the ACGIH Board of Directors for ratification as an NIC. If ratified, each proposed TLV or BEI is published as an NIC. At the same time, the draft Documentation is made available through ACGIH Customer Service or online at the ACGIH Publications Store and in the ACGIH DataHub. Following the NIC ratification by the ACGIH Board of Directors, interested parties, including ACGIH members and other scientific committees, are invited to provide data and substantive comments, preferably in the form of peer-reviewed literature, on the proposed TLVs or BEIs contained in the NIC. Should the data be from unpublished studies, ACGIH requires written authorization from the owner of the studies granting ACGIH permission to (1) use, (2) cite within the Documentation, and (3) upon request from a third party, release the information. All 3 permissions must be stated/covered in the written authorization (see endnote for a sample permission statement). The most effective and helpful comments address specific points within the draft Documentation. Changes or updates are made to the draft Documentation as necessary. If the committee finds or receives substantive data that change its scientific opinion regarding TLV or BEI values or notations, the committee may revise the proposal(s) and recommend to the ACGIH Board of Directors that it be retained as an NIC Documentation.

   Important Notice: The comment period for an NIC draft Documentation and its respective TLV(s), notation(s), or BEI(s) will be limited to a firm 3-month period twice a year, running from January 1 to March 31 and July 1 to September 30. ACGIH has structured the comment period to ensure all comments are received by ACGIH in time for full consideration by the appropriate committee before its spring and fall meetings. Because of the time required to properly review, evaluate, and consider comments during the meetings, any comments received after the deadlines will not be considered in committee deliberations regarding the outcome of the possible adoption of an NIC. As a general practice, ACGIH reviews all submissions regarding chemical substances and physical agents on the Under Study list, as well as NICs, or currently adopted BEI(s) or TLV(s). All comments received before March 31 will be considered in the fall meeting, and those received before September 30 will be considered in the spring meeting of the following year. Draft Documentation will be available for review during the comment period.

   When submitting comments, ACGIH requires that the submission be limited to 10 pages in length, including an executive summary. The submission may include appendices of citable material not included as part of the 10-page limit. It would be very beneficial to structure comments as follows:

   A. ***Executive Summary*** *– Provide an executive summary with a limit of 250 words.*
   B. ***List of Recommendations/Actions*** *– Identify, in a vertical list, specific recommendations/actions that are being requested.*

C. ***Rationale*** *– Provide specific rationale to justify each recommendation/action requested.*
D. ***Citable Material*** *– Provide citable material to substantiate the rationale.*

The above procedure will help ACGIH to more efficiently and productively review comments.

4. **TLV/BEI and Adopted Documentation:** If the committee neither finds nor receives any substantive data that change its scientific opinion regarding an NIC TLV or BEI (or notation), the committee may approve its recommendation to the ACGIH Board of Directors for adoption. Once approved by the committee and ratified by the Board, the TLV or BEI is published as adopted in the annual TLVs and BEIs book, and the TLV or BEI Documentation is finalized for print publication and included in the online DataHub.

5. **Withdraw from Consideration:** At any point in the process, the committee may determine not to proceed with developing a TLV or BEI and withdraw it from further consideration. Substances or physical agents withdrawn from consideration may be reconsidered by placement on the Under Study list (step 1 above).

Summary: There are *several important points* to consider throughout the above process:

A. The appropriate method for an interested party to contribute to the TLV and BEI process is through submitting peer-reviewed and public literature. ACGIH strongly encourages interested parties to publish their studies and not rely on unpublished studies as input to the TLV and BEI process. Also, the best time to submit comments to ACGIH is in the early stages of the TLV and BEI Development Process, preferably while the substance or agent is on the Under Study list.

B. An additional venue for presenting new data is an ACGIH-sponsored symposium or workshop that provides a platform for public discussion and scientific interpretation. ACGIH encourages input from external parties for suggestions on symposium topics, including suggestions about sponsors, speakers, and format. ACGIH employs several criteria to determine the appropriateness of a symposium. A key criterion is that the symposium must be the most efficient format to present the committee with information that will assist in the scientific judgment used for writing the Documentation and in setting the respective TLVs or BEIs. A symposium topic should be suggested while the substance/agent is under study, as symposia require considerable time, commitment, and resources to develop. Symposium topic suggestions submitted while a substance is on the NIC will be considered, but this is usually too late in the decision-making process. A symposium topic will not be favorably considered if its purpose is to provide a forum merely for voicing opinions about existing data. Rather, there must be ongoing research, scientific uncertainty about currently available data, or another scientific reason for the symposium. Symposium topic suggestions should be sent to the ACGIH Science Group (science@acgih.org).

C. ACGIH periodically receives requests from external parties to make a presentation to a committee about specific substances or issues. It is strictly by

exception that such requests are granted. While there are various reasons for this position, the underlying fact is that the committee focuses on data that have been peer-reviewed and published and not on data presented in a private forum. A committee may grant a request when the data are significantly new, have received peer review, are the best vehicle for receipt of the information, and are essential to the committee's deliberations. The presentation is not a forum to merely voice opinions about existing data. In order for a committee to evaluate such a request, the external party must submit a request in writing that, at a minimum, addresses the following elements: (a) a detailed description of the presentation; (b) a clear demonstration of why the information is important to the committee's deliberations; and (c) a clear demonstration of why a meeting is the necessary method of delivery. This request must be sent to the ACGIH Science Group (science@acgih.org). Also, the committee may initiate contact with outside experts (a) to meet with the committee to discuss specific issues or to obtain additional knowledge on the subject and (b) to provide written input or review of Documentation. This contact is only done on an as-needed basis, not as a routine practice.

D. ACGIH does *not* commit to deferring consideration of a new or revised TLV or BEI pending the outcome of proposed or ongoing research.

Important dates **to consider throughout each calendar year of the TLV/BEI Development Process:**

First Quarter:

- Public comments are accepted.[a]
- Committees meet.

Second Quarter:

- TLV/BEI Committees vote on proposed TLVs/BEIs for NIC or final adoption.[b]
- ACGIH Board of Directors votes on ratification of TLV/BEI Committee recommendations.

Third Quarter:

- Public comments are accepted.[a]
- Committes meet.

Fourth Quarter[b]:

- TLV/BEI Committees vote on proposed TLVs/BEIs for NIC or final adoption.

- ACGIH Board of Directors votes on ratification of TLV/BEI Committee recommendations.

[a] It is recommended that comments be submitted as early as practical, and no later than March 31 or September 30 to allow sufficient time for their proper consideration/review. This is particularly important for an NIC TLV/BEI.

[b] These actions typically occur early in the second and fourth quarters, but may occur during other times of the year.

Endnote

Sample permission statement granting ACGIH authorization to use, cite, and release unpublished studies:

[Name], [author or sponsor of the study**] grants permission to ACGIH to use and cite the documents listed below, and to fully disclose them to parties outside of ACGIH upon request. Permission to disclose the documents includes permission to make copies as needed.

Example: Joseph D. Doe, PhD, coauthor of the study, grants permission to ACGIH to use and cite the document listed below, and to fully disclose this document to parties outside of ACGIH. Permission to disclose the document includes permission to make copies as needed.

"Effects of quartz status on pharmacokinetics of intratracheally instilled cristobalite in rats [unpublished data]. March 21, 2003."

**This statement must be signed by an individual authorized to give this permission and should include contact information such as title and address.

Last revised November 2023

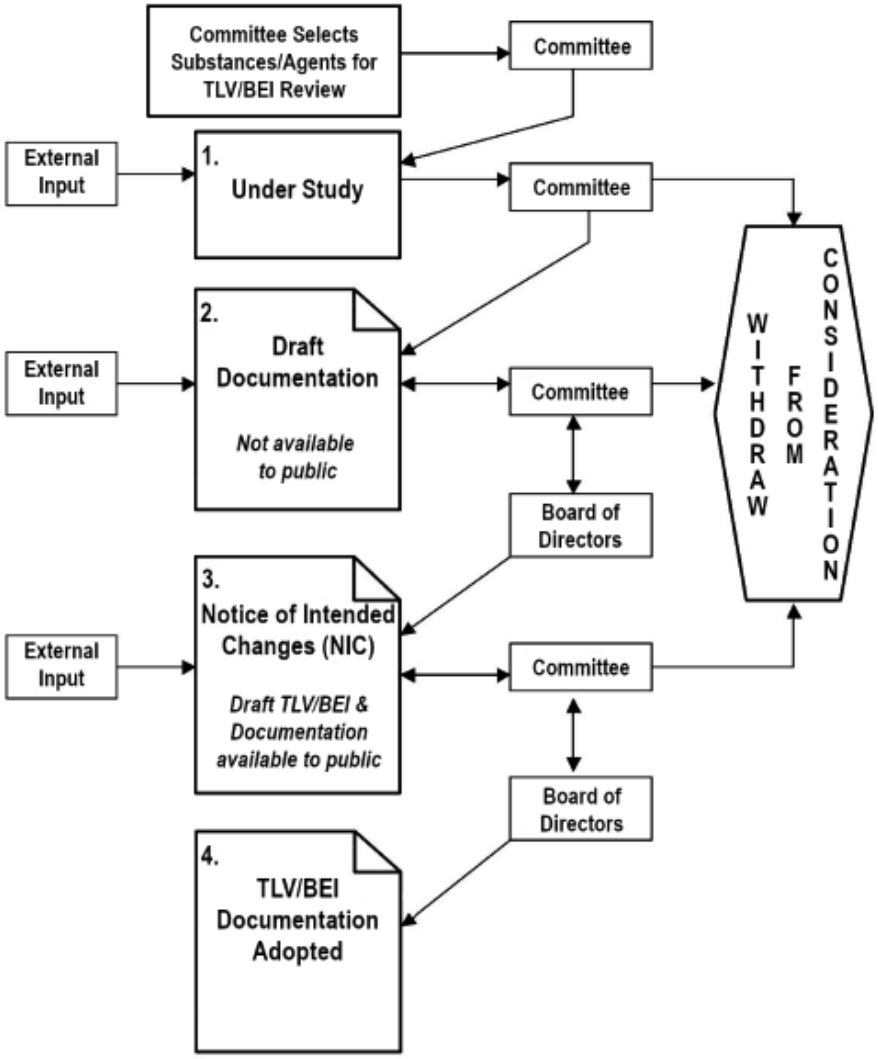


FIGURE 1. The TLV/BEI Development Process Flow Chart.

ONLINE TLV AND BEI RESOURCES

In an effort to make the TLVs and BEIs guideline establishment process more transparent, and to assist ACGIH members, government regulators, and industry groups in understanding the basis and limitations of the TLVs and BEIs, ACGIH has an online TLV/BEI Resources Section on its website at acgih.org/science/tlv-bei-guidelines/policies-procedures-presentations/tlv-bei-development.

The TLV/BEI Resources Section is divided into 8 categories, each containing clear and concise information. The categories are:

- **Conflict of Interest Policy** — applies to the Board of Directors, Committee Chairs, and Committee members (including consultant members), and safeguards the integrity and credibility of ACGIH programs and activities. The Policy, as well as ACGIH's oversight and review, each play an important part in the protection of ACGIH's programs and activities from inappropriate influences.

- **Notice of Intended Changes (NIC)** — a listing of the proposed actions of the TLV-CS, TLV-PA, and BEI Committees. This Notice provides an opportunity for public comment. Values remain on the NIC for a minimum of one comment period after they have been ratified by ACGIH's Board of Directors. The proposals should be considered trial values during the period they are on the NIC. If the Committee neither finds nor receives any substantive data that change its scientific opinion regarding an NIC TLV or BEI, the Committee may then approve its recommendation to the ACGIH Board of Directors for adoption. If the Committee finds or receives substantive data that change its scientific opinion regarding an NIC TLV or BEI, the Committee may change its recommendation to the ACGIH Board of Directors for the matter to be either retained on or withdrawn from the NIC.

- **TLV/BEI Policy Statement** — states what the TLVs and BEIs are and how they are intended to be used. While the TLVs and BEIs do contribute to the overall improvement in worker protection, the user must recognize the constraints and limitations subject to their proper use and bear the responsibility for such use.

- **TLV/BEI Position Statement** — expresses ACGIH's position on the TLVs and BEIs process. ACGIH is proud of the positive impact that the TLVs and BEIs have had on workers worldwide, and stands behind the hard work of its Committees to make the process more transparent and accessible. This section is presented in its entirety on pages v through vii.

- **TLV/BEI Development Process** — gives an overview of the process the Committees go through when establishing a TLV or BEI. This section is presented in its entirety on pages viii through xiii.

- **Committee Operations Manuals** — portable data files (PDF) of the Threshold Limit Values for Chemical Substances, the Threshold Limit Values for Physical Agents, and the Biological Exposure Indices Committees' Operations Manuals. Each Manual covers such areas as the Committee's mission, membership in the Committee, Committee make-up, internal and external communications with the Committee, flow of information, procedures for development of symposia and workshops, etc.

- **Under Study List** — substances or agents being actively researched or written about by the appropriate committee. Each Committee solicits data, comments, and suggestions that may assist in their deliberations about substances, agents, and issues on the Under Study list. Further, each Committee solicits recommendations for additional chemical substances, physical agents, and issues of concern to the industrial hygiene and occupational health communities.

REVISIONS OR ADDITIONS FOR 2024

All pertinent endnotes, abbreviations, and definitions relating to the materials in this publication appear on the inside back cover.

Chemical Substances Section

- Proposed TLVs that appeared on the 2023 NIC are adopted for the following substances:

Acetylsalicylic acid (aspirin)
Bensulide
Benzene
Buprofezin
tert-Butyl hydroperoxide
Captafol
Diacetyl
Epichlorohydrin
Ethylene glycol dimethyl ether
Fenoxycarb
Fentanyl and Fentanyl citrate, as Fentanyl
Formic acid
Halothane
Hexane (Commercial, <54% n-Hexane) and Branched Hexane Isomers
Methylcyclohexane
Methyl ethyl ketone
Pentaborane
Phenylethyl alcohol
Phthalic anhydride
Sevoflurane
Triclosan

- The following substances and proposed TLVs new to this section are placed on the NIC:

Desflurane
Imidacloprid
Propionitrile
Trimethylolpropane

- Revisions to adopted TLVs are proposed for the following substances and placed on the NIC:

Acrolein
Difluorodibromomethane
Isopropyl ether
Parathion

- The following substances are retained on the NIC without revised TLV recommendations or notations:

Dimethenamid-P
Endotoxins
Nitric acid
Trimetacresyl phosphate
Triparacresyl phosphate

Biological Exposure Indices (BEIs) Section

- The proposed BEIs that appeared on the 2023 NIC are adopted for the following substances:
  - Arsenic (and soluble inorganic compounds)
  - Di(2-ethylhexyl)phthalate
  - Xylenes (technical or commercial grades)

- The following substance is retained on the NIC without revised BEI recommendations or notations:
  Platinum

- Editorial changes to the Documentation are adopted for the following substance:
  Ethyl benzene

- Negative feasibility assessments were completed for the following substances:
  Adipates
  Formic acid

Physical Agents Section

- The following agents that appeared on the 2023 NIC with proposed changes or revisions are adopted:
  Above shoulder work
  Infrasound and low-frequency sound
  Whole-body vibration

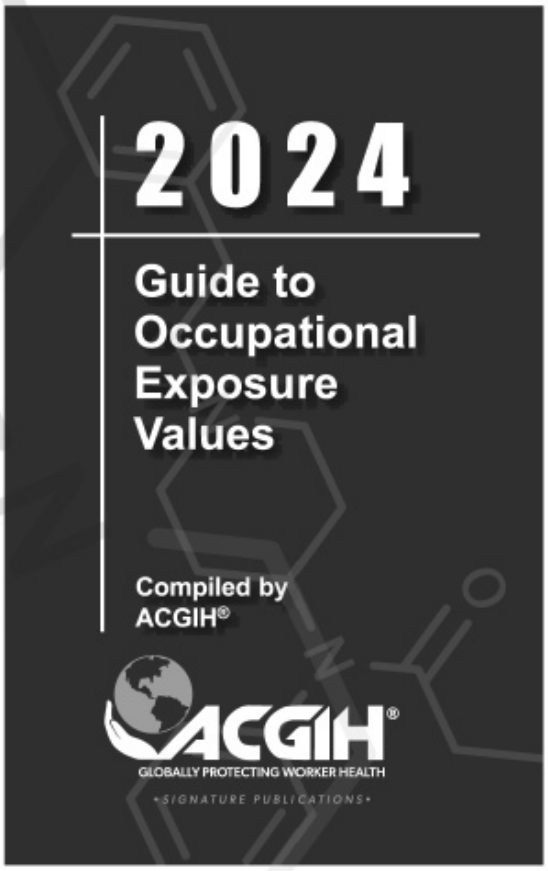
- A TLV for the following is proposed and placed on the NIC:
  Push/pull

- Editorial updates to the Documentation are adopted for the following agents:
  Ionizing radiation
  Ultraviolet radiation

Biological Agents Section

- A revision was made to the introduction to further clarify the definition of biological agents.

NEW FORMAT!
To Make It Easier for You



The ***2024 Guide to Occupational Exposure Values*** has been reformatted for your convenience! This new portrait orientation is now sized to 5″x8″ to make it easier for you to carry in the field.

This companion document to the ACGIH *TLVs and BEIs* book serves as a readily accessible reference for comparison of the most recently published values.

Order your copy today!

2024

Threshold Limit Values for Chemical Substances in the Work Environment

Adopted by ACGIH with Intended Changes

Contents

TLV–CS

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INTRODUCTION TO THE CHEMICAL SUBSTANCES

General Information

The TLVs are guidelines to be used by professional industrial hygienists. The values presented in this book are intended for use only as guidelines or recommendations to assist in the evaluation and control of potential workplace health hazards and for no other use (e.g., neither for evaluating or controlling community air pollution; nor for estimating the toxic potential of continuous, uninterrupted exposures or other extended work periods; nor for proving or disproving an existing disease or physical condition in an individual). Further, these values are not fine lines between safe and dangerous conditions and should not be used by anyone who is not trained in the discipline of industrial hygiene. TLVs are not regulatory or consensus standards.

Editor's note: The approximate year that the current Documentation was last substantially reviewed and, where necessary, updated may be found following the CAS number for each of the adopted entries in the alphabetical listing, e.g., Chromium [7440-47-3] and inorganic compounds (2017). The reader is advised to refer to the "TLV Chronology" section in each Documentation for a brief history of the TLV recommendations and notations.

Definition of the TLVs

Threshold Limit Values (TLVs) refer to airborne concentrations of chemical substances and represent conditions under which it is believed that *nearly all* workers may be repeatedly exposed, day after day, over a working lifetime, without adverse health effects.

Those who use the TLVs MUST consult the latest Documentation to ensure that they understand the basis for the TLV and the information used in its development. The amount and quality of the information that is available for each chemical substance varies over time.

Chemical substances with equivalent TLVs (i.e., same numerical values) cannot be assumed to have similar toxicologic effects or similar biologic potency. In this book, there are columns listing the TLVs for each chemical substance (that is, airborne concentrations in parts per million [ppm] or milligrams per cubic meter [mg/m^3]) and critical effects produced by the chemical substance. These critical effects form the basis of the TLV.

ACGIH recognizes that there will be considerable variation in the level of biological response to a particular chemical substance, regardless of the airborne concentration. Indeed, TLVs do not represent a fine line between a healthy versus an unhealthy work environment or the point at which material impairment of health will occur. TLVs will not adequately protect all workers. Some individuals may experience discomfort or even more serious adverse health effects when exposed to a chemical substance at the TLV or even at concentrations below the TLV. There are numerous possible reasons for increased susceptibility to a chemical substance, including age, gender, genetic factors (predisposition), lifestyle choices (e.g., diet, smoking, abuse of alcohol and other drugs), medications, and preexisting medical conditions

(e.g., aggravation of asthma or cardiovascular disease). Some individuals may become more responsive to one or more chemical substances following previous exposures (e.g., sensitized workers). Susceptibility to the effects of chemical substances may be altered during different periods of fetal development and throughout an individual's reproductive lifetime. Some changes in susceptibility may also occur at different work levels (e.g., light versus heavy work) or at exercise — situations in which there is increased cardiopulmonary demand. Additionally, variations in temperature (e.g., extreme heat or cold) and relative humidity may alter an individual's response to a toxicant. The Documentation for any given TLV must be reviewed, keeping in mind that other factors may modify biological responses.

Although TLVs refer to airborne levels of chemical exposure, dermal exposures may possibly occur in the workplace (*see* "Skin" on page 73 of the "Definitions and Notations" section).

Four categories of TLVs are specified: time-weighted average (TWA); short-term exposure limit (STEL); surface limit (SL); and ceiling (C). For most substances, a TWA alone or with a STEL is relevant. For some substances (e.g., irritant gases), only the TLV-STEL or TLV-C is applicable. If any of these TLV types are exceeded, a potential hazard from that substance is presumed to exist.

Threshold Limit Value–Time-Weighted Average (TLV-TWA): The TWA concentration for a conventional 8-hour workday and a 40-hour workweek, to which it is believed that nearly all workers may be repeatedly exposed, day after day, for a working lifetime without adverse effect. Although calculating the average concentration for a workweek, rather than a workday, may be appropriate in some instances, ACGIH does not offer guidance regarding such exposures.

Threshold Limit Value–Short-Term Exposure Limit (TLV-STEL): A 15-minute TWA exposure that should not be exceeded at any time during a workday, even if the 8-hour TWA is within the TLV-TWA. The TLV-STEL is the concentration to which it is believed that nearly all workers can be exposed continuously for a short period of time without suffering from (1) irritation, (2) chronic or irreversible tissue damage, (3) dose-rate-dependent toxic effects, or (4) narcosis of sufficient degree to increase the likelihood of accidental injury, impaired self-rescue, or materially reduced work efficiency. The TLV-STEL will not necessarily protect against these effects if the daily TLV-TWA is exceeded. The TLV-STEL usually supplements the TLV-TWA where there are recognized acute effects from a substance whose toxic effects are primarily of a chronic nature; however, the TLV-STEL may be a separate, independent exposure guideline. Exposures above the TLV-TWA up to the TLV-STEL (15-min TWA) should be less than 15 minutes, should occur no more than 4 times per day, and there should be at least 60 minutes between successive exposures in this range. An averaging period other than 15 minutes may be recommended when this is warranted by observed biological effects.

Threshold Limit Value–Surface Limit (TLV-SL): The concentration on workplace equipment and facility surfaces that is not likely to result in adverse effects following direct or indirect contact. The TLV-SL is intended to supplement airborne TLVs, especially those with Skin, DSEN, and RSEN notations, to provide quantitative criteria for establishing acceptable surface concentrations expressed as mg/100 cm^2. For systemic effects, consistent with the use of

the Skin notation, the TLV-SL will often correspond to the dose permitted by the TLV–TWA over an 8-hour period, unless chemical-specific data are available linking adverse effects with surface sample results. For certain dermal sensitizers, the surface limit may be established using potency estimates from animal studies, such as the effective concentration causing a 3-fold increase in lymphocyte proliferation (EC3) and applying an appropriate adjustment factor.[1] For other sensitizers, including some respiratory sensitizers that cause induction of sensitization via dermal exposure, professional judgment may be required to supplement available surface and airborne monitoring results.

Threshold Limit Value–Ceiling (TLV-C): The concentration that should not be exceeded during any part of the working exposure. If instantaneous measurements are not available, sampling should be conducted for the minimum period of time sufficient to detect exposures at or above the ceiling value. ACGIH believes that TLVs based on physical irritation should be considered no less binding than those based on physical impairment. There is increasing evidence that physical irritation may initiate, promote, or accelerate adverse health effects through interaction with other chemical or biologic agents or through other mechanisms.

Peak Exposures

The TLV Committee recommends consideration of a TLV-STEL if there are supporting data. For many substances with a TLV-TWA, there is no TLV-STEL. Nevertheless, short-term peak exposures above the TLV-TWA should be controlled, even where the 8-hour TLV-TWA is within recommended limits. Limiting short-term high exposures is intended to prevent rapidly occurring acute adverse health effects resulting from transient peak exposures during a workshift. Since these adverse effects may occur at some multiple of the 8-hour TWA, even if they have not yet been documented, it is prudent to limit peak exposures. Therefore, the following default short-term exposure limits apply to those TLV-TWAs that do not have a TLV-STEL:

> *Transient increases in workers' exposure levels may exceed 3 times the value of the TLV-TWA level for no more than 15 minutes at a time, on no more than 4 occasions spaced 1 hour apart during a workday, and under no circumstances should they exceed 5 times the value of the TLV-TWA level when measured as a 15-min TWA. In addition, the 8-hour TWA is not to be exceeded for an 8-hour work period.*

This guidance on limiting peak exposures above the value of the TLV-TWA is analogous to that for the TLV-STEL, and both represent 15-minute exposure limits. The consistency in approach is intended to encourage minimizing process variability and ensuring worker protection. Good design and industrial hygiene practice ensures that processes are controlled within acceptable ranges. Historically, guidance on peak exposures (formerly excursion limits) has been based purely on statistical considerations: if log-normally distributed, short-term exposure values for a well-controlled process have a geometric standard deviation of 2.0, then 5% of all values will exceed 3.13 times the geometric

mean. Processes that display greater variability are not under good control, and efforts should be made to restore control. Higher exposure levels also increase the possibility that acute health effects may occur, which were probably not factored into the TLV-TWA if it was based on prevention of chronic effects. The maximum peak exposure factor of 5 also reflects this concern about undesirable health effects. Limiting peak exposures reduces the probability of exceeding the TLV-TWA. When initial samples indicate peak exposures beyond these recommendations, more careful assessment is needed, especially when dealing with unusual work schedules.

The so-called "3 by 5 Rule", as described above, should be considered a rule of thumb, and a pragmatic precautionary approach. It is recognized that the geometric standard deviations of some common workplace exposures may exceed 2.0. If such distributions are known, and it can be shown that workers are not at increased risk of adverse health effects, recommended peak exposure guidelines may be modified based on workplace-specific and compound-specific health effects data. For example, consideration should be given to dose-rate effects and elimination half-times for the particular substance and for similar compounds. Special consideration should also be given to unusual work schedules and whether the peak exposure factors should be applied to the TLV-TWA (e.g., if concerns for acute health effects predominate) or the adjusted TWA (e.g., if the concern is with exceeding the adjusted TWA). The practicing hygienist must use judgment in applying this guidance on peak exposures. When a TLV-STEL or a TLV-C is available, this value takes precedence over the above guidance for peak exposures.

TWA and STEL versus Ceiling (C)

A substance may have certain toxicological properties that require the use of a TLV-C rather than a TLV-STEL or peak exposure guidance above a TLV-TWA. The amount by which the TLVs may be exceeded for short periods without injury to health depends upon a number of factors such as the nature of the contaminant, whether very high concentrations — even for short periods — produce acute poisoning, whether the effects are cumulative, the frequency with which high concentrations occur, and the duration of such periods. All factors must be taken into consideration in arriving at a decision as to whether a hazardous condition exists.

Although the TWA concentration provides the most satisfactory, practical way of monitoring airborne agents for compliance with the TLVs, there are certain substances for which it is inappropriate. In the latter group are substances that are predominantly fast-acting and whose TLV is more appropriately based on the concentration associated with this particular response. Substances with this type of response are best controlled by a TLV-C that should not be exceeded. It is implicit in these definitions that the manner of sampling to determine noncompliance with the TLVs for each group must differ. Consequently, a single, brief sample that is applicable to a TLV-C is not appropriate to the TLV-TWA; here, a sufficient number of samples is needed to permit determination that the TLV-C is not exceeded at any time during a complete cycle of operation or throughout the workshift.

Whereas the TLV-C places a definite boundary that exposure concentrations should not be permitted to exceed, the TLV-TWA requires an explicit limit to the number and duration of peak exposures which are acceptable above the recommended TLV-TWAs.

Mixtures

Special consideration should also be given to the application of the TLVs in assessing the health hazards that may be associated with exposure to a mixture of two or more substances. A brief discussion of basic considerations involved in developing TLVs for mixtures and methods for their development, amplified by specific examples, is given in Appendix E.

Deviations in Work Conditions and Work Schedules

Application of TLVs to Unusual Ambient Conditions

When workers are exposed to air contaminants at temperatures and pressures substantially different than those at 25°C and 760 torr, care should be taken in comparing sampling results to the applicable TLVs. For aerosols, the TWA exposure concentration (calculated using sample volumes not adjusted to conditions at 25°C and 760 torr) should be compared directly to the applicable TLVs published in the *TLVs and BEIs* book. For gases and vapors, there are a number of options for comparing air-sampling results to the TLV, and these are discussed in detail by Stephenson and Lillquist.[2] One method that is simple in its conceptual approach is (1) to determine the exposure concentration, expressed in terms of mass per volume, at the sampling site using the sample volume not adjusted to conditions at 25°C and 760 torr, (2) if required, to convert the TLV to mg/m^3 (or other mass per volume measure) using a molar volume of 24.45 L/mole, and (3) to compare the exposure concentration to the TLV, both in units of mass per volume.

A number of assumptions are made when comparing sampling results obtained under unusual atmospheric conditions to the TLVs. One such assumption is that the volume of air inspired by the worker per workday is not appreciably different under moderate conditions of temperature and pressure as compared to those at 25°C and 760 torr.[2] An additional assumption for gases and vapors is that absorbed dose is correlated to the partial pressure of the inhaled compound. Sampling results obtained under unusual conditions cannot easily be compared to the published TLVs, and extreme care should be exercised if workers are exposed to very high or low ambient pressures.

Unusual Work Schedules

Application of TLVs to work schedules markedly different from the conventional 8-hour day, 40-hour workweek requires particular judgment to provide protection for these workers equal to that provided to workers on conventional workshifts. Short workweeks can allow workers to have more than one job, perhaps with similar exposures, and may result in overexposure, even if neither job by itself entails overexposure.

Numerous mathematical models to adjust for unusual work schedules have been described. In terms of toxicologic principles, their general objective is to

identify a dose that ensures that the daily peak body burden or weekly peak body burden does not exceed that which occurs during a normal 8-hour/day, 5-day/week shift. A comprehensive review of the approaches to adjusting occupational exposure limits for unusual work schedules is provided in *Patty's Industrial Hygiene*.[3] Please see other selected readings on this topic listed at the end of this section.[4-10]

Another model that addresses unusual work schedules is the Brief and Scala model,[11] which is explained in detail in *Patty's Industrial Hygiene*.[3] This model reduces the TLV proportionately for both increased exposure time and reduced recovery (i.e., nonexposure) time, and is generally intended to apply to work schedules longer than 8 hours/day or 40 hours/week. The model should not be used to justify very high exposures as "allowable" where the exposure periods are short (e.g., exposure to 8 times the TLV-TWA for 1 hour and zero exposure during the remainder of the shift). In this respect, the general limitations on peak exposures above the TLV-TWA and TLV-STELs should be applied to avoid inappropriate use of the model with very short exposure periods or shifts.

The Brief and Scala model[11] is easier to use than some of the more complex models based on pharmacokinetic actions. The application of such models usually requires knowledge of the biological half-life of each substance, and some models require additional data. Another model developed by the University of Montreal and the Institute de Recherche en Sante et en Securite du Travail (IRSST) uses the Haber method to calculate adjusted exposure limits.[5] This method generates values close to those obtained from physiologically based pharmacokinetic (PBPK) models.

Because adjusted TLVs do not have the benefit of historical use and long-time observation, medical supervision during initial use of adjusted TLVs is advised. Unnecessary exposure of workers should be avoided, even if a model shows such exposures to be "allowable." Mathematical models should not be used to justify higher-than-necessary exposures.

TLV Units

TLVs are expressed in ppm, mg/m^3, mg/100 cm^2, or µg. An inhaled chemical substance may exist as a gas, vapor, or aerosol.

- A gas is a chemical substance whose molecules are moving freely within a space in which they are confined (e.g., cylinder/tank) at 25°C and 760 torr. Gases assume no shape or volume.
- A vapor is the gaseous phase of a chemical substance that exists as a liquid or a solid at 25°C and 760 torr. The amount of vapor given off by a chemical substance is expressed as the vapor pressure and is a function of temperature and pressure.
- An aerosol is a suspension of solid particles or liquid droplets in a gaseous medium. Other terms used to describe an aerosol include dust, mist, fume, fog, fiber, smoke, and smog. Aerosols may be characterized by their aerodynamic behavior and the site(s) of deposition in the human respiratory tract.

TLVs for aerosols are usually established in terms of mass of the chemical substance in air by volume. These TLVs are expressed in mg/m^3.

TLVs for gases and vapors are established in terms of parts of vapor or gas per million parts of contaminated air by volume (ppm), but may also be expressed in mg/m^3. For convenience to the user, these TLVs also reference molecular weights. Where 24.45 = molar volume of air in liters at 25°C and 760 torr, the conversion equations for gases and vapors [ppm ↔ mg/m^3] are as follows:

$$\text{TLV in ppm} = \frac{(\text{TLV in mg/m}^3)\ (24.45)}{(\text{gram molecular weight of substance})}$$

OR

$$\text{TLV in mg/m}^3 = \frac{(\text{TLV in ppm})\ (\text{gram molecular weight of substance})}{24.45}$$

When converting values for volatile forms of inorganic compounds (e.g., as Fe, as Ni), the molecular weight of the element should be used, not that of the entire compound.

In making conversions for substances with variable molecular weights, appropriate molecular weights should be estimated or assumed (*see* the TLV Documentation).

User Information

Each TLV is supported by a comprehensive Documentation. It is imperative to consult the latest Documentation when applying the TLV. Consult the ACGIH website (portal.acgih.org/s/store#/store/browse/cat/a0s4W00000g02f3QAA/tiles) for additional information and availability concerning these publications.

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Selected Readings

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Leidel NA, Busch KA, Crouse WE. Exposure measurement action level and occupational environmental variability. Cincinnati (OH): US Department of Health E, and Welfare; 1975. Report No.: 76-131. https://stacks.cdc.gov/view/cdc/11153.

All pertinent notes relating to the material in the Chemical Substances section of this book appear in the appendices for this section or on the inside back cover.

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Acetaldehyde [75-07-0] (2014)	—	C 25 ppm	A2	44.05	Eye & URT irr
Acetamide [60-35-5] (2017)	1 ppm (IFV)	—	A3	59.07	Liver cancer & dam
Acetamiprid [135410-20-7] (2022)	0.05 mg/m^3 (IFV)	—	A4	222.68	Steatosis; neurodevelopment, immune system, & CNS impair; male repro system dam; repro eff
Acetic acid [64-19-7] (2004)	10 ppm	15 ppm	—	60.05	URT & eye irr; pulm func
Acetic anhydride [108-24-7] (2011)	1 ppm	3 ppm	A4	102.09	Eye & URT irr
Acetone [67-64-1] (2015)	250 ppm	500 ppm	A4; BEI	58.08	URT & eye irr; CNS impair
Acetone cyanohydrin [75-86-5], as CN (1994)	—	C 5 mg/m^3	Skin	85.10	URT irr; headache; hypoxia/cyanosis
Acetonitrile [75-05-8] (2002)	20 ppm	—	Skin; A4	41.05	LRT irr
Acetophenone [98-86-2] (2009)	10 ppm	—	—	120.15	URT irr; CNS impair; pregnancy loss
Acetylene [74-86-2]	*See* Appendix F: Minimal Oxygen Content (D, EX)			26.04	Asphyxia
* Acetylsalicylic acid (aspirin) [50-78-2] (2023)	0.3 mg/m^3	—	Skin; RSEN; OTO; A4	180.15	Bleeding; resp sens
‡ Acrolein [107-02-8] (1998)	—	(C 0.1 ppm)	Skin; (A4)	56.06	Eye irr (URT irr; pulm edema; pulm emphysema)
Acrylamide [79-06-1] (2020)	0.03 mg/m^3 (IFV)	—	Skin; DSEN; A2; BEI	71.08	CNS & PNS impair; cancer
Acrylic acid [79-10-7] (1996)	2 ppm	—	Skin; A4	72.06	URT irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Acrylonitrile [107-13-1] (2016)	2 ppm	—	Skin; A3	53.05	CNS impair; LRT irr
Adipic acid [124-04-9] (1993)	5 mg/m^3	—	—	146.14	Eye, skin, URT irr; ANS impair
Adiponitrile [111-69-3] (1994)	2 ppm	—	Skin	108.10	URT & LRT irr
Alachlor [15972-60-8] (2014)	1 mg/m^3 (IFV)	—	DSEN; A3	269.80	Hemosiderosis (liver, spleen, kidney)
Aldicarb [116-06-3] (2018)	0.005 mg/m^3 (IFV)	—	Skin; A4; BEI_C	190.26	Cholinesterase inhib
Aldrin [309-00-2] (2007)	0.05 mg/m^3 (IFV)	—	Skin; A3	364.93	CNS impair; liver & kidney dam
Allyl alcohol [107-18-6] (1999)	0.5 ppm	—	Skin; A4	58.08	Eye & URT irr
Allyl bromide [106-95-6] (2012)	0.1 ppm	0.2 ppm	Skin; A4	120.99	Eye & URT irr
Allyl chloride [107-05-1] (2011)	1 ppm	2 ppm	Skin; A3	76.50	Eye & URT irr; liver & kidney dam
Allyl glycidyl ether [106-92-3] (1997)	1 ppm	—	A4	114.14	URT, eye, & skin irr; dermatitis
Allyl methacrylate [96-05-9] (2018)	1 ppm	—	Skin	126.15	Liver dam
Allyl propyl disulfide [2179-59-1] (2014)	0.5 ppm	—	DSEN	148.16	URT & eye irr
Aluminum metal [7429-90-5] and insoluble compounds (2008)	1 mg/m^3 (R)	—	A4	26.98 Varies	Pneumoconiosis; LRT irr; neurotoxicity
4-Aminodiphenyl [92-67-1] (1987)	— (L)	—	Skin; A1	169.24	Bladder & liver cancer
2-Aminopyridine [504-29-0] (1986)	0.5 ppm	—	—	94.12	Headache; nausea; CNS impair; dizziness

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Amitrole [61-82-5] (1995)	0.2 mg/m^3	—	A3	84.08	Thyroid eff
Ammonia [7664-41-7] (1976)	25 ppm	35 ppm	—	17.03	Eye dam; URT irr
Ammonium chloride, fume [12125-02-9] (1976)	10 mg/m^3	20 mg/m^3	—	53.50	Eye & URT irr
Ammonium perfluorooctanoate [3825-26-1] (1994)	0.01 mg/m^3	—	Skin; A3	431.00	Liver dam
Ammonium sulfamate [7773-06-0] (1984)	10 mg/m^3	—	—	114.13	—
tert-Amyl methyl ether [994-05-8] (2002)	20 ppm	—	—	102.20	CNS impair; embryo/fetal dam
Aniline [62-53-3] (1996)	2 ppm	—	Skin; A3; BEI	93.13	MeHb-emia
Anisidine (2002)					
ortho isomer [90-04-0]	0.5 mg/m^3	—	Skin; A3; BEI$_M$	123.15	MeHb-emia
para isomer [104-94-9]	0.5 mg/m^3	—	Skin; A4; BEI$_M$	123.15	MeHb-emia
Antimony [7440-36-0] and compounds, as Sb (1995)	0.5 mg/m^3	—	—	121.75	Skin & URT irr
Antimony hydride [7803-52-3] (2021)	0.005 ppm	—	—	124.78	Hemolysis, hemotologic effects
Antimony trioxide [1309-64-4] (2021)	0.02 mg/m^3 (I)	—	A2	291.50	Pneumonitis
ANTU [86-88-4] (1996)	0.3 mg/m^3	—	A4; Skin	202.27	Thyroid eff; nausea
Argon [7440-37-1]	*See* Appendix F: Minimal Oxygen Content (D)			39.95	Asphyxia
Arsenic [7440-38-2] and inorganic compounds, as As (1992)	0.01 mg/m^3	—	A1; BEI	74.92 Varies	Lung cancer

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Arsine [7784-42-1] (2007)	0.005 ppm	—	—	77.95	PNS & vascular system impair; kidney & liver impair
Asbestos [1332-21-4], all forms (1998)	0.1 f/cc (F)	—	A1	—	Pneumoconiosis; lung cancer; mesothelioma
Asphalt (Bitumen) fumes [8052-42-4], as benzene-soluble aerosol (2000)	0.5 mg/m^3 (I)	—	A4; BEI_P	—	URT & eye irr
Atrazine [1912-24-9] (and related symmetrical triazines) (2014)	2 mg/m^3 (I)	—	A3	215.69	Hematologic, repro, & developmental eff
Azinphos-methyl [86-50-0] (2014)	0.2 mg/m^3 (IFV)	—	Skin; DSEN; A4; BEI_C	317.34	Cholinesterase inhib
Barium [7440-39-3] and soluble compounds, as Ba (1996)	0.5 mg/m^3	—	A4	137.30	Eye, skin, & GI irr; muscular stimulation
Barium sulfate [7727-43-7] (2014)	5 mg/m^3 (I, E)	—	—	233.43	Pneumoconiosis
Bendiocarb [22781-23-3] (2018)	0.1 mg/m^3 (IFV)	—	Skin; A4; BEI_C	223.20	Cholinesterase inhib
Benomyl [17804-35-2] (2014)	1 mg/m^3 (I)	—	DSEN; A3	290.32	URT irr; male repro, testicular, & embryo/fetal dam
Benz[a]anthracene [56-55-3] (1993)	— (L)	—	A2; BEI_P	228.30	Skin cancer
* Bensulide [741-58-2] (2023)	0.1 mg/m^3 (IFV)	—	A4; BEI_C	397.5	Cholinesterase inhib; liver dam

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
* Benzene [71-43-2] (2023)	0.02 ppm	—	Skin; A1; BEI	78.11	Myelodysplastic syndrome; acute myeloid leukemia; leukemia; hematologic eff; chromosomal dam
Benzidine [92-87-5] (1985)	— (L)	—	Skin; A1	184.23	Bladder cancer
Benzo[b]fluoranthene [205-99-2] (1991)	— (L)	—	A2; BEI_P	252.30	Cancer
Benzo[a]pyrene [50-32-8] (1990)	— (L)	—	A2; BEI_P	252.30	Cancer
Benzoic acid and alkali benzoates (2021)					
Benzoic acid [65-85-0]	0.5 mg/m^3 (IFV)	—	Skin; A5	122.12	Eye irr, URT irr, LRT irr; lung dam
Sodium benzoate, as benzoate [532-32-1]	2.5 mg/m^3 (I)	—	Skin; A5	144.10	Kidney changes
Potassium benzoate, as benzoate [582-25-2]	2.5 mg/m^3 (I)	—	Skin; A5	160.21	Kidney changes
Benzoquinone [106-51-4] (2022)	0.1 ppm SL 5 µg/100 cm^2		DSEN; A4	108.09	Eye & URT irr; ocular eff
Benzotrichloride [98-07-7] (1997)	—	C 0.1 ppm	Skin; A2	195.50	Eye, skin, & URT irr
Benzoyl chloride [98-88-4] (1995)	—	C 0.5 ppm	A4	140.57	URT & eye irr
Benzoyl peroxide [94-36-0] (1996)	5 mg/m^3	—	A4	242.22	URT & skin irr
Benzyl acetate [140-11-4] (1995)	10 ppm	—	A4	150.18	URT irr
Benzyl chloride [100-44-7] (1995)	1 ppm	—	A3	126.58	Eye, skin, & URT irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Beryllium [7440-41-7] and compounds, as Be (2014)	0.00005 mg/m^3 (I)	—	A1	9.01	Beryllium sens; chronic beryllium disease (berylliosis)
Soluble compounds			Skin; DSEN		
Soluble and insoluble compounds			RSEN		
Biphenyl [92-52-4] (1987)	0.2 ppm	—	—	154.20	Pulm func
Bismuth telluride [1304-82-1] (1996)				800.83	Lung dam
Undoped, as Bi_2Te_3	10 mg/m^3	—	A4		
Se-doped, as Bi_2Te_3	5 mg/m^3	—	A4		
Borate compounds, inorganic [1303-96-4; 1330-43-4; 10043-35-3; 12179-04-3] (2005)	2 mg/m^3 (I)	6 mg/m^3 (I)	A4	Varies	URT irr
Boron oxide [1303-86-2] (1985)	10 mg/m^3	—	—	69.64	Eye & URT irr
Boron tribromide [10294-33-4] (2016)	—	C 0.7 ppm	—	250.57	Resp tract irr; pneumonitis
Boron trichloride [10294-34-5] (2016)	—	C 0.7 ppm	—	117.20	Resp tract irr; pneumonitis
Boron trifluoride [7637-07-2] (2016)	0.1 ppm	C 0.7 ppm	—	67.82	Resp tract irr; pneumonitis
Boron trifluoride ethers [109-63-7; 353-42-4], as BF_3 (2018)	0.1 ppm	C 0.7 ppm	—	Varies	Resp tract irr; pneumonitis
Bromacil [314-40-9] (1996)	10 mg/m^3	—	A3	261.11	Thyroid eff

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Bromine [7726-95-6] (1994)	0.1 ppm	0.2 ppm	—	159.81	URT & LRT irr; lung dam
Bromine pentafluoride [7789-30-2] (1986)	0.1 ppm	—	—	174.92	Eye, skin, & URT irr
Bromoform [75-25-2] (2009)	0.5 ppm	—	A3	252.73	Liver dam; URT & eye irr
1-Bromopropane [106-94-5] (2014)	0.1 ppm	—	A3	122.99	CNS impair; peripheral neuropathy; hematological eff; developmental & repro toxicity (male & female)
* Buprofezin [69327-76-0] (2023)	0.5 mg/m$^{3(IFV)}$	—	DSEN; A4	305.4	Liver & thyroid eff
1,3-Butadiene [106-99-0] (1994)	2 ppm	—	A2; BEI	54.09	Cancer
Butane, isomers [75-28-5; 106-97-8] (2017)	—	1,000 ppm (EX)	—	58.12	CNS impair
n-Butanol [71-36-3] (2001)	20 ppm	—	—	74.12	Eye & URT irr
sec-Butanol [78-92-2] (2002)	100 ppm	—	—	74.12	URT irr; CNS impair
tert-Butanol [75-65-0] (1995)	100 ppm	—	A4	74.12	CNS impair
Butenes, all isomers [106-98-9; 107-01-7; 590-18-1; 624-64-6; 25167-67-3]	250 ppm	—	—	56.11	Body weight eff
Isobutene [115-11-7] (2008)	250 ppm	—	A4	—	URT irr; body weight eff
2-Butoxyethanol [111-76-2] (2003)	20 ppm	—	A3; BEI	118.17	Eye & URT irr
2-Butoxyethyl acetate [112-07-2] (2003)	20 ppm	—	A3	160.20	Hemolysis

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Butyl acetates, all isomers [105-46-4; 110-19-0; 123-86-4; 540-88-5] (2016)	50 ppm	150 ppm	—	116.16	Eye & URT irr
Butylated hydroxytoluene [128-37-0] (2001)	2 mg/m^3 (IFV)	—	A4	220.34	URT irr
n-Butyl acrylate [141-32-2] (2014)	2 ppm	—	DSEN; A4	128.17	Irr
n-Butylamine [109-73-9] (1985)	—	C 5 ppm	Skin	73.14	Headache; URT & eye irr
n-Butyl glycidyl ether [2426-08-6] (2014)	3 ppm	—	Skin; DSEN	130.21	Reproduction; sens
n-Butyl lactate [138-22-7] (1976)	5 ppm	—	—	146.19	Headache; URT irr
n-Butyl mercaptan [109-79-5] (1970)	0.5 ppm	—	—	90.19	URT irr
o-sec-Butylphenol [89-72-5] (1980)	5 ppm	—	Skin	150.22	URT, eye, & skin irr
p-tert-Butyltoluene [98-51-1] (1993)	1 ppm	—	—	148.18	Eye & URT irr; nausea
4-tert-Butylbenzoic acid [98-73-7] (2020)	0.1 mg/m^3 (IFV)	—	Skin	178.20	Testicular dam; CNS & male repro eff
tert-Butyl chromate, as CrO_3 [1189-85-1] (1964)	—	C 0.1 mg/m^3	Skin	230.22	LRT & skin irr
* tert-Butyl hydroperoxide [75-91-2] (2023)	0.1 ppm	—	A2	90.12	URT, LRT, & eye dam; nasal cancer
Cadmium [7440-43-9] and	0.01 mg/m^3	—	A2; BEI	112.40	Kidney dam
compounds, as Cd (1993)	0.002 mg/m^3 (R)	—	A2; BEI	Varies	

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Cadusafos [95465-99-9] (2017)	0.001 mg/m^3 (IFV)	—	Skin; A4; BEI$_C$	270.40	Cholinesterase inhib
Calcium cyanamide [156-62-7] (1996)	0.5 mg/m^3	—	A4	80.11	Eye & URT irr
Calcium hydroxide [1305-62-0] (1979)	5 mg/m^3	—	—	74.10	Eye, URT, & skin irr
Calcium oxide [1305-78-8] (1990)	2 mg/m^3	—	—	56.08	URT irr
Calcium silicate, naturally occurring as Wollastonite [13983-17-0] (2016)	1 mg/m^3 (I, E)	—	A4	—	Pneumoconiosis; pulm func
Calcium sulfate [7778-18-9; 10034-76-1; 10101-41-4; 13397-24-5] (2006)	10 mg/m^3 (I)	—	—	136.14	Nasal symptoms
Camphor, synthetic [76-22-2] (1996)	2 ppm	3 ppm	A4	152.23	Eye & URT irr; anosmia
Caprolactam [105-60-2] (2003)	5 mg/m^3 (IFV)	—	A5	113.16	URT irr
* Captafol [2425-06-1] (2023)	0.1 mg/m^3 (IFV) SL 0.2 mg/100 cm^2	—	DSEN; RSEN; A3	349.10	Liver & kidney dam; resp & dermal sens
Captan [133-06-2] (2014)	5 mg/m^3 (I)	—	DSEN; A3	300.60	Skin irr
Carbaryl [63-25-2] (2008)	0.5 mg/m^3 (IFV)	—	Skin; A4; BEI$_C$	201.20	Cholinesterase inhib; male repro & embryo dam
Carbofuran [1563-66-2] (2004)	0.1 mg/m^3 (IFV)	—	A4; BEI$_C$	221.30	Cholinesterase inhib

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Carbon black [1333-86-4] (2011)	3 mg/m^3 (I)	—	A3	—	Bronchitis
Carbon dioxide [124-38-9] (1986)	5,000 ppm	30,000 ppm	—	44.01	Asphyxia
Carbon disulfide [75-15-0] (2006)	1 ppm	—	Skin; A4; BEI	76.14	PNS impair
Carbon monoxide [630-08-0] (1992)	25 ppm	—	BEI	28.01	COHb-emia
Carbon tetrabromide [558-13-4] (1976)	0.1 ppm	0.3 ppm	—	331.65	Liver dam; eye, URT, & skin irr
Carbon tetrachloride [56-23-5] (1996)	5 ppm	10 ppm	Skin; A2	153.84	Liver dam
Carbonyl fluoride [353-50-4] (1990)	2 ppm	5 ppm	—	66.01	LRT irr; bone dam
Carbonyl sulfide [463-58-1] (2012)	5 ppm	—	—	60.08	CNS impair
Carfentrazone-ethyl [128639-02-1] (2018)	1 mg/m^3 (I)	—	A4	412.20	Liver dam; porphyrin eff
Catechol [120-80-9] (1995)	5 ppm	—	Skin; A3	110.11	Eye & URT irr; dermatitis
Cellulose [9004-34-6] (1990)	10 mg/m^3	—	—	NA	URT irr
Cesium hydroxide [21351-79-1] (1990)	2 mg/m^3	—	—	149.92	URT, skin, & eye irr
Chlordane [57-74-9] (2019)	0.5 mg/m^3 (IFV)	—	Skin; A3	409.80	Liver dam
Chlorinated camphene [8001-35-2] (1996)	0.5 mg/m^3	1 mg/m^3	Skin; A3	414.00	CNS convul; liver dam
Chlorinated diphenyl oxide [31242-93-0] (1990)	0.5 mg/m^3	—	—	377.00	Chloracne; liver dam

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Chlorine [7782-50-5] (2018)	0.1 ppm	0.4 ppm	A4	70.91	Resp tract irr; airway hyper-reactivity; pulm edema
Chlorine dioxide [10049-04-4] (2018)	—	C 0.1 ppm	—	67.46	Resp tract irr; pulm edema
Chlorine trifluoride [7790-91-2] (1979)	—	C 0.1 ppm	—	92.46	Eye & URT irr; lung dam
Chloroacetaldehyde [107-20-0] (1990)	—	C 1 ppm	—	78.50	URT & eye irr
Chloroacetone [78-95-5] (1989)	—	C 1 ppm	Skin	92.53	Eye & URT irr
2-Chloroacetophenone [532-27-4] (1996)	0.05 ppm	—	A4	154.59	Eye, URT, & skin irr
Chloroacetyl chloride [79-04-9] (1991)	0.05 ppm	0.15 ppm	Skin	112.95	URT irr
Chlorobenzene [108-90-7] (1995)	10 ppm	—	A3; BEI	112.56	Liver dam
o-Chlorobenzylidene malononitrile [2698-41-1] (2019)	—	C 0.05 ppm (IFV)	Skin; A4	188.62	URT irr; skin sens
Chlorobromomethane [74-97-5] (2009)	200 ppm	—	—	129.39	CNS impair; liver dam
Chlorodifluoromethane [75-45-6] (1996)	1,000 ppm	—	A4	86.47	CNS impair; asphyxia; card sens
Chlorodiphenyl (42% chlorine) [53469-21-9] (1990)	1 mg/m^3	—	Skin	266.50	Liver dam; eye irr; chloracne
Chlorodiphenyl (54% chlorine) [11097-69-1] (1996)	0.5 mg/m^3	—	Skin; A3	328.40	URT irr; liver dam; chloracne
Chloroform [67-66-3] (1995)	10 ppm	—	A3	119.38	Liver & embryo/fetal dam; CNS impair

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
bis(Chloromethyl) ether [542-88-1] (1987)	0.001 ppm	—	A1	114.96	Lung cancer
Chloromethyl methyl ether [107-30-2] (1983)	— (L)	—	A2	80.50	Lung cancer
1-Chloro-1-nitropropane [600-25-9] (2017)	2 ppm	—	—	123.54	Eye & URT irr; pulm edema
Chloropentafluoroethane [76-15-3] (1981)	1,000 ppm	—	—	154.47	Card sens
Chloropicrin [76-06-2] (1996)	0.1 ppm	—	A4	164.39	Eye irr; pulm edema
β-Chloroprene [126-99-8] (2017)	1 ppm	—	Skin; A2	88.54	Lung cancer; URT & eye irr
1-Chloro-2-propanol [127-00-4] and 2-Chloro-1-propanol [78-89-7] (2002)	1 ppm	—	Skin; A4	94.54	Liver dam
2-Chloropropionic acid [598-78-7] (1991)	0.1 ppm	—	Skin	108.53	Male repro dam
o-Chlorostyrene [2039-87-4] (1976)	50 ppm	75 ppm	—	138.60	CNS impair; peripheral neuropathy
o-Chlorotoluene [95-49-8] (1990)	50 ppm	—	—	126.59	URT, eye, & skin irr
Chlorpyrifos [2921-88-2] (2003)	0.1 mg/m^3 (IFV)	—	Skin; A4; BEI_C	350.57	Cholinesterase inhib

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Chromium, [7440-47-3] and inorganic compounds (2018)					
Metallic chromium, as Cr(0)	0.5 mg/m^3 (I)	—	—	Varies	Resp tract irr
Trivalent chromium compounds, as Cr(III)	0.003 mg/m^3 (I)	—	A4	Varies	Resp tract irr; asthma
Water-soluble compounds			DSEN; RSEN		
Hexavalent chromium compounds, as Cr(VI)	0.0002 mg/m^3 (I)	0.0005 mg/m^3 (I)	A1	Varies	Lung & sinonasal cancer; resp tract irr; asthma
Water-soluble compounds			Skin; DSEN; RSEN; BEI		
Chromyl chloride [14977-61-8], as Cr(VI)	0.0001 ppm (IFV)	0.00025 ppm (IFV)	Skin; DSEN; RSEN; A1	Varies	Lung & sinonasal cancer; resp tract irr; asthma
Chromite ore processing	*See* Hexavalent and Trivalent Chromium compounds				
Chrysene [218-01-9] (1996)	— (L)	—	A3; BEI$_P$	228.30	Cancer
Citral [5392-40-5] (2014)	5 ppm (IFV)	—	Skin; DSEN; A4	152.24	Body weight eff; URT irr; eye dam
Clopidol [2971-90-6] (2013)	3 mg/m^3 (IFV)	—	A4	192.06	Mutagenic eff
Clothianidin [210880-92-5] (2021)	0.1 mg/m^3 (I)		A4	249.67	Male & female repro system dam; neurobehavioral & neurodevelopment impair; body weight eff
Coal dust (1998)					
Anthracite [8029-10-5]	0.4 mg/m^3 (R)	—	A4	—	Lung dam; pulm fibrosis
Bituminous or Lignite [308062-82-0]	0.9 mg/m^3 (R)	—	A4	—	Lung dam; pulm fibrosis

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Coal tar pitch volatiles [65996-93-2], as benzene soluble aerosol (1991)	0.2 mg/m^3	—	A1; BEI$_P$	—	Cancer
Cobalt [7440-48-4] and inorganic compounds, as Co (2019)	0.02 mg/m^3 (I)	—	DSEN;RSEN; A3; BEI	58.93 Varies	Pulm func changes
Cobalt carbonyl [10210-68-1], as Co (1983)	0.1 mg/m^3	—	—	341.94	Pulm edema; spleen dam
Cobalt hydrocarbonyl [16842-03-8], as Co (1983)	0.1 mg/m^3	—	—	171.98	Pulm edema; lung dam
Copper [7440-50-8] (1990)				63.55	Irr; GI; metal fume fever
Fume, as Cu	0.2 mg/m^3	—	—		
Dusts and mists, as Cu	1 mg/m^3	—	—		
Cotton dust, raw, untreated (2010)	0.1 mg/m^3 (T)	—	A4	—	Byssinosis; bronchitis; pulm func
Coumaphos [56-72-4] (2006)	0.05 mg/m^3 (IFV)	—	Skin; A4; BEI$_C$	362.80	Cholinesterase inhib
Cresol, all isomers [95-48-7; 106-44-5; 108-39-4; 1319-77-3] (2010)	20 mg/m^3 (IFV)	—	Skin; A4	108.14	URT irr
Crotonaldehyde [4170-30-3] (1998)	—	C 0.3 ppm	Skin; A3	70.09	Eye & URT irr
Crufomate [299-86-5] (1996)	5 mg/m^3	—	A4; BEI$_C$	291.71	Cholinesterase inhib
Cumene [98-82-8] (2021)	5 ppm	—	A3	120.19	URT adenoma; neurological eff
Cyanamide [420-04-2] (1977)	2 mg/m^3	—	—	42.04	Skin & eye irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Cyanazine [21725-46-2] (2019)	0.1 mg/m^3 (I)	—	A3	240.70	Body weight, CNS & teratogenic eff
Cyanoacrylates, Ethyl [7085-85-0] and Methyl [137-05-3] (2018)	0.2 ppm	1 ppm	DSEN; RSEN	125.4 (Ethyl) 112.11 (Methyl)	Eye & URT irr; asthma
Cyanogen [460-19-5] (2016)	—	C 5 ppm	—	52.04	Eye & URT irr
Cyanogen bromide [506-68-3] (2015)	—	C 0.3 ppm	—	105.92	Eye & resp tract irr; pulm edema
Cyanogen chloride [506-77-4] (2014)	—	C 0.3 ppm	—	61.48	Pulm edema; eye, skin, & URT irr
Cyclohexane [110-82-7] (2020)	100 ppm	—	BEI	84.16	CNS impair; eye & URT irr
Cyclohexanol [108-93-0] (1986)	50 ppm	—	Skin; BEI	100.16	Eye irr; CNS impair
Cyclohexanone [108-94-1] (2003)	20 ppm	50 ppm	Skin; A3; BEI	98.14	Eye & URT irr
Cyclohexene [110-83-8] (2020)	20 ppm	—	—	82.14	Liver eff
Cyclohexylamine [108-91-8] (1995)	10 ppm	—	A4	99.17	URT & eye irr
Cyclonite [121-82-4] (1996)	0.5 mg/m^3	—	Skin; A4	222.26	Liver dam
Cyclopentane [287-92-3] (2021)	1,000 ppm (EX)	—		70.13	CNS impair
Cyhexatin [13121-70-5] (1995)	5 mg/m^3	—	A4	385.16	URT irr; body weight eff; kidney dam

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Cyromazine [66215-27-8] (2021)	2 mg/m^3 (I)	—	A4	166.19	Body weight & hematological eff
2,4-D [94-75-7] (2017)	10 mg/m^3 (I)	—	A4	221.04	Thyroid eff; kidney tubular dam
DDT [50-29-3] (1995)	1 mg/m^3	—	A3	354.50	Liver dam
Decaborane [17702-41-9] (1979)	0.05 ppm	0.15 ppm	Skin	122.31	CNS convul; cognitive decrement
Demeton [8065-48-3] (2002)	0.05 mg/m^3 (IFV)	—	Skin; BEI_C	258.34	Cholinesterase inhib
Demeton-S-methyl [919-86-8] (2014)	0.05 mg/m^3 (IFV)	—	Skin; DSEN; A4; BEI_C	230.30	Cholinesterase inhib
Diacetone alcohol [123-42-2] (1987)	50 ppm	—	—	116.16	URT & eye irr
* Diacetyl [431-03-8] (2023)	0.01 ppm	0.02 ppm	DSEN; A3	86.10	Lung dam
Diazinon [333-41-5] (2003)	0.01 mg/m^3 (IFV)	—	Skin; A4; BEI_C	304.36	Cholinesterase inhib
Diazomethane [334-88-3] (1996)	0.2 ppm	—	A2	42.04	URT & eye irr
Diborane [19287-45-7] (1990)	0.1 ppm	—	—	27.69	URT irr; headache
2-N-Dibutylaminoethanol [102-81-8] (1994)	0.5 ppm	—	Skin; BEI_C	173.29	Eye & URT irr
Dibutyl phenyl phosphate [2528-36-1] (1990)	0.3 ppm	—	Skin; BEI_C	286.26	Cholinesterase inhib; URT irr
Dibutyl phosphate [107-66-4] (2009)	5 mg/m^3 (IFV)	—	Skin	210.21	Bladder, eye, & URT irr
Dibutyl phthalate [84-74-2] (1990)	5 mg/m^3	—	—	278.34	Testicular dam; eye & URT irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Dichloroacetic acid [79-43-6] (2005)	0.5 ppm	—	Skin; A3	128.95	URT & eye irr; testicular dam
Dichloroacetylene [7572-29-4] (1995)	—	C 0.1 ppm	A3	94.93	Nausea; PNS impair
o-Dichlorobenzene [95-50-1] (1996)	25 ppm	50 ppm	A4	147.01	URT & eye irr; liver dam
p-Dichlorobenzene [106-46-7] (1993)	10 ppm	—	A3	147.01	Eye irr; kidney dam
3,3'-Dichlorobenzidine [91-94-1] (1996)	— (L)	—	Skin; A3	253.13	Bladder cancer; eye irr
1,4-Dichloro-2-butene [764-41-0] (1993)	0.005 ppm	—	Skin; A2	124.99	URT & eye irr
Dichlorodifluoromethane [75-71-8] (1996)	1,000 ppm	—	A4	120.91	Card sens
1,3-Dichloro-5,5-dimethylhydantoin [118-52-5] (1979)	0.2 mg/m^3	0.4 mg/m^3	—	197.03	URT irr
1,1-Dichloroethane [75-34-3] (1996)	100 ppm	—	A4	98.97	URT & eye irr; liver & kidney dam
1,2-Dichloroethylene, all isomers [156-59-2; 156-60-5; 540-59-0] (1990)	200 ppm	—	—	96.95	CNS impair; eye irr
Dichloroethyl ether [111-44-4] (1996)	5 ppm	10 ppm	Skin; A4	143.02	URT & eye irr; nausea
Dichlorofluoromethane [75-43-4] (1980)	10 ppm	—	—	102.92	Liver dam
Dichloromethane [75-09-2] (1999)	50 ppm	—	A3; BEI	84.93	COHb-emia; CNS impair
1,1-Dichloro-1-nitroethane [594-72-9] (1986)	2 ppm	—	—	143.96	URT irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
1,3-Dichloropropene [542-75-6] (2004)	1 ppm	—	Skin; A3	110.98	Kidney dam
2,2-Dichloropropionic acid [75-99-0] (2000)	5 mg/m^3 (I)	—	A4	143.00	Eye & URT irr
Dichlorotetrafluoroethane [76-14-2] (1996)	1,000 ppm	—	A4	170.93	Pulm func
Dichlorvos [62-73-7] (2014)	0.1 mg/m^3 (IFV)	—	Skin; DSEN; A4; BEI$_C$	220.98	Cholinesterase inhib
Dicrotophos [141-66-2] (2002)	0.05 mg/m^3 (IFV)	—	Skin; A4; BEI$_C$	237.21	Cholinesterase inhib
Dicyclopentadiene [77-73-6], including Cyclopentadiene [542-92-7] (2019)	0.5 ppm	1 ppm	—	132.21	URT, LRT, & eye irr; CNS eff
Dicyclopentadienyl iron, as Fe [102-54-5] (1990)	10 mg/m^3	—	—	186.03	Liver dam
Dieldrin [60-57-1] (2010)	0.1 mg/m^3 (IFV)	—	Skin; A3	380.93	Liver dam; repro eff; CNS impair
Diesel fuel [68334-30-5; 68476-30-2; 68476-31-3; 68476-34-6], as total hydrocarbons (2008)	100 mg/m^3 (IFV)	—	Skin; A3	Varies	Dermatitis
Diethanolamine [111-42-2] (2009)	1 mg/m^3 (IFV)	—	Skin; A3	105.14	Liver & kidney dam
Diethylamine [109-89-7] (2013)	5 ppm	15 ppm	Skin; A4	73.14	URT, eye, & skin irr
2-Diethylaminoethanol [100-37-8] (1994)	2 ppm	—	Skin	117.19	URT irr; CNS convul

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Diethylene glycol monobutyl ether [112-34-5] (2013)	10 ppm (IFV)	—	—	162.23	Hematologic, liver & kidney eff
Diethylenetriamine [111-40-0] (1985)	1 ppm	—	Skin	103.17	URT & eye irr
Di(2-ethylhexyl)phthalate [117-81-7] (2022)	0.1 mg/m^3	—	Skin; A3	390.54	Male repro system dam; teratogenic eff
N,N-Diethylhydroxylamine [3710-84-7] (2013)	2 ppm	—	—	89.14	URT irr
Diethyl ketone [96-22-0] (1998)	200 ppm	300 ppm	—	86.13	URT irr; CNS impair
Diethyl phthalate [84-66-2] (1999)	5 mg/m^3	—	A4	222.23	URT irr
‡ Difluorodibromomethane [75-61-6] (1986)	100 ppm	—	—	209.83	(URT irr; CNS impair); liver dam ( )
Diglycidyl ether [2238-07-5] (2007)	0.01 ppm	—	A4	130.14	Eye & skin irr; male repro dam
Diisobutyl ketone [108-83-8] (1979)	25 ppm	—	—	142.23	URT & eye irr
Diisopropylamine [108-18-9] (1979)	5 ppm	—	Skin	101.19	URT irr; eye dam
Dimethylacetamide [127-19-5] (2018)	10 ppm	—	Skin; A3; BEI	87.12	Liver, embryo & fetal dam; repro, renal & teratogenic eff
Dimethylamine [124-40-3] (2014)	5 ppm	15 ppm	DSEN; A4	45.08	URT & GI irr
bis(2-Dimethylaminoethyl) ether [3033-62-3] (2000)	0.05 ppm	0.15 ppm	Skin	160.26	URT, eye, & skin irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Dimethylaniline [121-69-7] (1996)	5 ppm	10 ppm	Skin; A4; BEI_M	121.18	MeHb-emia
Dimethyl carbamoyl chloride [79-44-7] (2018)	0.005 ppm	—	Skin; A2	107.54	Nasal cancer; URT irr
Dimethyl disulfide [624-92-0] (2007)	0.5 ppm	—	Skin	94.20	URT irr; CNS impair
Dimethylethoxysilane [14857-34-2] (1996)	0.5 ppm	1.5 ppm	—	104.20	URT & eye irr; headache
Dimethylformamide [68-12-2] (2018)	5 ppm	—	Skin; A3; BEI	73.10	Liver dam; eye & URT irr
1,1-Dimethylhydrazine [57-14-7] (1995)	0.01 ppm	—	Skin; A3	60.12	URT irr; nasal cancer
Dimethylphenol, all isomers [95-65-8; 95-87-4; 105-67-9; 108-68-9; 526-75-0; 576-26-1; 1300-71-6] (2019)	1 ppm (IFV)	—	DSEN; A3	Varies	Hematologic & body weight eff
Dimethyl phthalate [131-11-3] (2005)	5 mg/m^3	—	—	194.19	Eye & URT irr
Dimethyl sulfate [77-78-1] (1995)	0.1 ppm	—	Skin; A3	126.10	Eye & skin irr
Dimethyl sulfide [75-18-3] (2004)	10 ppm	—	—	62.14	URT irr
Dinitrobenzene, all isomers [99-65-0; 100-25-4; 528-29-0; 25154-54-5] (2018)	0.15 ppm (IFV)	—	Skin; BEI_M	168.11	MeHb-emia; eye dam
Dinitro-o-cresol [534-52-1] (2019)	0.2 mg/m^3 (IFV)	—	Skin	198.13	Basal metabolism
3,5-Dinitro-o-toluamide [148-01-6] (2007)	1 mg/m^3	—	A4	225.16	Liver dam

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Dinitrotoluene [25321-14-6] (1997)	0.2 mg/m^3	—	Skin; A3; BEI_M	182.15	Card impair; repro eff
1,4-Dioxane [123-91-1] (1999)	20 ppm	—	Skin; A3	88.10	Liver dam
Dioxathion [78-34-2] (2002)	0.1 mg/m^3 (IFV)	—	Skin; A4; BEI_C	456.54	Cholinesterase inhib
1,3-Dioxolane [646-06-0] (2002)	20 ppm	—	—	74.08	Hematologic eff
Diphenylamine [122-39-4] (1996)	10 mg/m^3	—	A4	169.24	Liver & kidney dam; hematologic eff
Dipropyl ketone [123-19-3] (1981)	50 ppm	—	—	114.80	URT irr
Dipropylene glycol methyl ether (DPGME) [13429-07-7; 13588-28-8; 20324-32-7; 34590-94-8; 55956-21-3] (2021)	50 ppm	—	—	148.20	Liver & CNS eff
Diquat [85-00-7; 2764-72-9; 6385-62-2], as the cation (1996)	0.5 mg/m^3 (I) 0.1 mg/m^3 (R)	— —	Skin; A4 Skin; A4	Varies	LRT irr; cataract LRT irr; cataract
Disulfiram [97-77-8] (1995)	2 mg/m^3	—	A4	296.54	Vasodilation; nausea
Disulfoton [298-04-4] (2002)	0.05 mg/m^3 (IFV)	—	Skin; A4; BEI_C	274.38	Cholinesterase inhib
Diuron [330-54-1] (1996)	10 mg/m^3	—	A4	233.10	URT irr
Divinylbenzene [1321-74-0] (1990)	10 ppm	—	—	130.19	URT irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Divinylbenzene-ethyl styrene mixtures, as total divinylbenzene isomers [69011-19-4; 7525-62-4; 108-57-6; 105-06-6] (2022)	0.5 ppm	—	DSEN; A3	130.20	URT & lung dam
Dodecyl mercaptan [112-55-0] (2014)	0.1 ppm	—	DSEN	202.40	URT irr
Endosulfan [115-29-7] (2009)	0.1 mg/m^3 (IFV)	—	Skin; A4	406.95	LRT irr; liver & kidney dam
Endrin [72-20-8] (1996)	0.1 mg/m^3	—	Skin; A4	380.93	Liver dam; CNS impair; headache
Enflurane [13838-16-9] (1996)	75 ppm	—	A4	184.50	CNS impair; card impair
* Epichlorohydrin [106-89-8] (2023)	0.1 ppm	—	Skin; DSEN; A2	92.53	Resp tract irr
EPN [2104-64-5] (2019)	0.1 mg/m^3 (IFV)	—	Skin; A4; BEI$_C$	323.31	Cholinesterase inhib
Ethane [74-84-0]	See Appendix F: Minimal Oxygen Content (D, EX)			30.07	Asphyxia
Ethanol [64-17-5] (2009)	—	1,000 ppm	A3	46.07	URT irr
Ethanolamine [141-43-5] (1985)	3 ppm	6 ppm	—	61.08	Eye & skin irr
Ethion [563-12-2] (2003)	0.05 mg/m^3 (IFV)	—	Skin; A4; BEI$_C$	384.48	Cholinesterase inhib
2-Ethoxyethanol [110-80-5] (2003)	5 ppm	—	Skin; BEI	90.12	Male repro & embryo/fetal dam
2-Ethoxyethyl acetate [111-15-9] (2003)	5 ppm	—	Skin; BEI	132.16	Male repro dam

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Ethyl acetate [141-78-6] (1979)	400 ppm	—	—	88.10	URT & eye irr
Ethyl acrylate [140-88-5] (1996)	5 ppm	15 ppm	A4	100.11	URT, eye, & GI irr; CNS impair; skin sens
Ethylamine [75-04-7] (2013)	5 ppm	15 ppm	Skin	45.08	URT irr
Ethyl amyl ketone [541-85-5] (2007)	10 ppm	—	—	128.21	Neurotoxicity
Ethyl benzene [100-41-4] (2021)	20 ppm	—	OTO; A3; BEI	106.16	URT & eye irr; ototoxicity; kidney eff; CNS impair
Ethyl bromide [74-96-4] (1996)	5 ppm	—	Skin; A3	108.98	Liver dam; CNS impair
Ethyl tert-butyl ether [637-92-3] (2013)	25 ppm	—	A4	102.18	URT & LRT irr; CNS impair
Ethyl butyl ketone [106-35-4] (1998)	50 ppm	75 ppm	—	114.19	CNS impair; eye & skin irr
Ethyl chloride [75-00-3] (1995)	100 ppm	—	Skin; A3	64.52	Liver dam
Ethylene [74-85-1] (2005)	200 ppm	—	A4	28.05	Asphyxia
Ethylene chlorohydrin [107-07-3] (1996)	—	C 1 ppm	Skin; A4	80.52	CNS impair; liver & kidney dam
Ethylenediamine [107-15-3] (1996)	10 ppm	—	Skin; A4	60.10	—
Ethylene dibromide [106-93-4] (1995)	—	—	Skin; A3	187.88	—

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Ethylene dichloride [107-06-2] (1996)	10 ppm	—	A4	98.96	Liver dam; nausea
Ethylene glycol [107-21-1] (2017)	25 ppm (V)	50 ppm (V) 10 mg/m^3 (I, H)	A4	62.07	URT irr
* Ethylene glycol dimethyl ether [110-71-4] (2023)	0.5 ppm	—	Skin	90.12	Hematologic & male repro eff; embryo/fetal dam
Ethylene glycol dinitrate [628-96-6] (2022)	SL 0.02 mg/100 cm^2	0.01 ppm	Skin	152.06	Vasodilation; headache; hypotension; cerebrovascular & cardiovascular disease
Ethylene oxide [75-21-8] (1990)	1 ppm	—	A2; Skin; BEI	44.05	Cancer; CNS impair
Ethyleneimine [151-56-4] (2009)	0.05 ppm	0.1 ppm	Skin; A3	43.08	URT irr; liver & kidney dam
Ethyl ether [60-29-7] (1976)	400 ppm	500 ppm	—	74.12	CNS impair; URT irr
Ethyl formate [109-94-4] (2012)	—	100 ppm	A4	74.08	URT irr
2-Ethylhexanoic acid [149-57-5] (2007)	5 mg/m^3 (IFV)	—	—	144.24	Teratogenic eff
2-Ethyl-1-hexanol [104-76-7] (2022)	5 ppm	—	A3	130.23	URT & eye irr
Ethylidene norbornene [16219-75-3] (2014)	2 ppm	4 ppm	—	120.19	URT & eye irr
Ethyl isocyanate [109-90-0] (2014)	0.02 ppm	0.06 ppm	Skin; DSEN	71.10	URT & eye irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Ethyl mercaptan [75-08-1] (2004)	0.5 ppm	—	—	62.13	URT irr; CNS impair
N-Ethylmorpholine [100-74-3] (1986)	5 ppm	—	Skin	115.18	URT irr; eye dam
Ethyl silicate [78-10-4] (1986)	10 ppm	—	—	208.30	URT & eye irr; kidney dam
Fenamiphos [22224-92-6] (2006)	0.05 mg/m^3 (IFV)	—	Skin; A4; BEI_C	303.40	Cholinesterase inhib
* Fenoxycarb [72490-01-8] (2023)	1 mg/m^3 (I)	—	A3	301.3	Liver & lung dam
Fensulfothion [115-90-2] (2005)	0.01 mg/m^3 (IFV)	—	Skin; A4; BEI_C	308.35	Cholinesterase inhib
* Fentanyl [437-38-7] and Fentanyl citrate [990-73-8], as Fentanyl (2023)	0.1 µg/m^3 (I) SL 1 µg/100 cm^2	0.2 µg/m^3 (I)	Skin; A4	336.5 528.6	CNS impair; Resp depression
Fenthion [55-38-9] (2006)	0.05 mg/m^3 (IFV)	—	Skin; A4; BEI_C	278.34	Cholinesterase inhib
Ferbam [14484-64-1] (2009)	5 mg/m^3 (I)	—	A4	416.50	CNS impair; body weight eff; spleen dam
Ferrovanadium dust [12604-58-9] (1990)	1 mg/m^3	3 mg/m^3	—	—	Eye, URT, & LRT irr
Flour dust (2014)	0.5 mg/m^3 (I)	—	RSEN	—	Asthma; URT irr; bronchitis
Fludioxonil [131341-86-1 (2018)	1 mg/m^3 (I)	—	A3	248.20	Liver & kidney dam
Fluorides, as F (1996)	2.5 mg/m^3	—	A4; BEI	Varies	Bone dam; fluorosis
Fluorine [7782-41-4], as F (2019)	0.1 ppm	C 0.5 ppm	—	38.00	Fluorosis; eye irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Folpet [133-07-3] (2017)	1 mg/m^3 (I)	—	DSEN; A3	296.60	Liver dam; body weight eff
Fonofos [944-22-9] (2006)	0.1 mg/m^3 (IFV)	—	Skin; A4; BEI_C	246.32	Cholinesterase inhib
Formaldehyde [50-00-0] (2017)	0.1 ppm	0.3 ppm	DSEN; RSEN; A1	30.03	URT & eye irr; URT cancer
Formamide [75-12-7] (2020)	1 ppm	—	Skin; A3	45.04	Hematological eff; liver cancer; developmental toxicity
* Formic acid [64-18-6] (2023)	5 ppm	—	—	46.02	URT irr
Furfural [98-01-1] (2017)	0.2 ppm	—	Skin; A3; BEI	96.08	URT & eye irr
Furfuryl alcohol [98-00-0] (2017)	0.2 ppm	—	Skin; A3	98.10	URT & eye irr
Gallium arsenide [1303-00-0] (2007)	0.0003 mg/m^3 (R)	—	A3	144.64	LRT irr
Gasoline [86290-81-5] (2003)	300 ppm	500 ppm	A3	Varies	URT & eye irr; CNS impair
Germanium tetrahydride [7782-65-2] (1986)	0.2 ppm	—	—	76.63	Hematologic eff
Glutaraldehyde [111-30-8], activated or unactivated (2015)	—	C 0.05 ppm	DSEN; RSEN; A4	100.11	URT, skin, & eye irr; CNS impair
Glycidol [556-52-5] (1996)	2 ppm	—	A3	74.08	URT, eye, & skin irr
Glycidyl methacrylate [106-91-2] (2022)	0.01 ppm	—	Skin; DSEN; A2	142.15	URT dam & irr; mutagenic eff; cancer

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Glyoxal [107-22-2] (2014)	0.1 mg/m^3 (IFV)	—	DSEN; A4	58.04	URT irr; larynx metaplasia
Glyphosate [1071-83-6] (2022)	5 mg/m^3 (I)	—	A4	169.07	Body weight eff; liver dam; cataract
Grain dust (oat, wheat, barley) (1986)	4 mg/m^3	—	—	NA	Bronchitis; URT irr; pulm func
Graphite (all forms except graphite fibers) [7782-42-5] (1991)	2 mg/m^3 (R)	—	—	—	Pneumoconiosis
Hafnium [7440-58-6] and compounds, as Hf (1996)	0.5 mg/m^3	—	—	178.49	URT & eye irr; liver dam
* Halothane [151-67-7] (2023)	5 ppm	—	A4	197.39	Developmental eff; liver dam; CNS impair
Hard metals containing Cobalt [7440-48-4] and Tungsten carbide [12070-12-1], as Co (2016)	0.005 mg/m^3 (T)	—	RSEN; A2	—	Pneumonitis
Helium [7440-59-7]	*See* Appendix F: Minimal Oxygen Content (D)			4.00	Asphyxia
Heptachlor [76-44-8] and Heptachlor epoxide [1024-57-3] (1990)	0.05 mg/m^3	—	Skin; A3	373.32 389.40	Liver dam
Heptane, isomers [108-08-7; 142-82-5; 565-59-3; 589-34-4; 590-35-2; 591-76-4] (1979)	400 ppm	500 ppm	—	100.20	CNS impair; URT irr
Hexachlorobenzene [118-74-1] (1997)	0.002 mg/m^3	—	Skin; A3	284.78	Porphyrin eff; skin dam; CNS impair
Hexachlorobutadiene [87-68-3] (1995)	0.02 ppm	—	Skin; A3	260.76	Kidney dam

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Hexachlorocyclopentadiene [77-47-4] (1996)	0.01 ppm	—	A4	272.75	URT irr
Hexachloroethane [67-72-1] (1996)	1 ppm	—	Skin; A3	236.74	Liver & kidney dam
Hexachloronaphthalene [1335-87-1] (1986)	0.2 mg/m^3	—	Skin	334.74	Liver dam; chloracne
Hexafluoroacetone [684-16-2] (1986)	0.1 ppm	—	Skin	166.02	Testicular & kidney dam
Hexafluoropropylene [116-15-4] (2010)	0.1 ppm	—	—	150.02	Kidney dam
Hexahydrophthalic anhydride, all isomers [85-42-7; 13149-00-3; 14166-21-3] (2015)	—	C 0.005 mg/m^3 (IFV)	RSEN	154.17	Sens
Hexamethylene diisocyanate [822-06-0] (1988)	0.005 ppm	—	BEI	168.22	URT irr; resp sens
Hexamethylenetetramine [100-97-0] (2021)	1 mg/m^3 (IFV)	—	DSEN; A4	140.19	Dermal sens
Hexamethyl phosphoramide [680-31-9] (1996)	—	—	Skin; A3	179.20	URT cancer
* Hexane (Commercial, <54% n-Hexane) and Branched Hexane Isomers (2023)					
Hexane (Commercial, <54% n-Hexane) [Varies, including 64742-49-0, 64742-89-8]	100 ppm	—	Skin; A3	—	Periph neuropathy
Branched Hexane Isomers [75-83-2, 79-29-8, 107-83-5, 96-14-0]	200 ppm	—	A3	86.18	URT irr; lung dam
n-Hexane [110-54-3] (1998)	50 ppm	—	Skin; BEI	86.18	CNS impair; peripheral neuropathy; eye irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
1,6-Hexanediamine [124-09-4] (1992)	0.5 ppm	—	—	116.21	URT & skin irr
Hexazinone [51235-04-2] (2020)	3 mg/m^3 (I)	—	A4	252.30	Hematological & liver eff
1-Hexene [592-41-6] (2000)	50 ppm	—	—	84.16	CNS impair
sec-Hexyl acetate [108-84-9] (2020)	20 ppm	50 ppm	—	144.21	CNS impair; URT & eye irr
Hexylene glycol [107-41-5] (2017)	25 ppm (V)	50 ppm (V) 10 mg/m^3 (I, H)	—	118.18	Eye & URT irr
Hydrazine [302-01-2] (1995)	0.01 ppm	—	Skin; A3	32.05	URT cancer
Hydrogen [1333-74-0]	See Appendix F: Minimal Oxygen Content (D, EX)			1.01	Asphyxia
Hydrogenated terphenyls (nonirradiated) [61788-32-7] (1990)	0.5 ppm	—	—	241.00	Liver dam
Hydrogen bromide [10035-10-6] (2001)	—	C 2 ppm	—	80.92	URT irr
Hydrogen chloride [7647-01-0] (2002)	—	C 2 ppm	A4	36.47	URT irr
Hydrogen cyanide and cyanide salts, as CN (1994)					URT irr; headache; nausea; thyroid eff
Hydrogen cyanide [74-90-8]	—	C 4.7 ppm	Skin	27.03	
Cyanide salts [143-33-9; 151-50-8; 592-01-8]	—	C 5 mg/m^3	Skin	Varies	
Hydrogen fluoride [7664-39-3], as F (2004)	0.5 ppm	C 2 ppm	Skin; BEI	20.01	URT, LRT, skin, & eye irr; fluorosis
Hydrogen peroxide [7722-84-1] (1996)	1 ppm	—	A3	34.02	Eye, URT, & skin irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Hydrogen selenide [7783-07-5], as Se (1990)	0.05 ppm	—	—	80.98	URT & eye irr; nausea
Hydrogen sulfide [7783-06-4] (2010)	1 ppm	5 ppm	—	34.08	URT irr; CNS impair
Hydroquinone [123-31-9] (2014)	1 mg/m^3	—	DSEN; A3	110.11	Eye irr; eye dam
2-Hydroxypropyl acrylate [999-61-1] (2014)	0.5 ppm	—	Skin; DSEN	130.14	Eye & URT irr
Imazosulfuron [122548-33-8] (2021)	10 mg/m^3 (I)	—	A4	412.80	Thyroid & liver hypertrophy
Indene [95-13-6] (2008)	5 ppm	—	—	116.15	Liver dam
Indium [7440-74-6] and compounds, as In (1990)	0.1 mg/m^3	—	BEI	114.82	Pulm edema; pneumonitis; dental erosion; malaise
Indium tin oxide [50926-11-9], as In (2019)	0.0001 mg/m^3 (R)	—	DSEN; A3; BEI	Varies	Pulm func; pulm fibrosis
Iodine and Iodides, (2022)					Thyroid & maternal repro eff; fetal & neonatal dam
Iodine, as I [7553-56-2]	0.001 ppm (IFV)	—	Skin; A4	253.80	
Iodides, as I	0.01 mg/m^3 (I)	—	Skin; A4		
Iodoform [75-47-8] (2021), as elemental Iodine	0.001 ppm (IFV)	—	Skin; A4	393.73	Thyroid eff; fetal/neonatal dam
Iron oxide (Fe_2O_3) [1309-37-1] (2006)	5 mg/m^3 (R)	—	A4	159.70	Pneumoconiosis
Iron pentacarbonyl [13463-40-6], as Fe (1982)	0.1 ppm	0.2 ppm	—	195.90	Pulm edema; CNS impair
Iron salts, soluble, as Fe (1990)	1 mg/m^3	—	—	Varies	URT & skin irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Isoamyl alcohol [123-51-3] (1990)	100 ppm	125 ppm	—	88.15	Eye & URT irr
Isobutanol [78-83-1] (2002)	50 ppm	—	—	74.12	Skin & eye irr
Isobutyl nitrite [542-56-3] (2019)	—	C 1 ppm	A3; BEI_M	103.12	MeHb-emia; Vasodilation
Isoflurane [26675-46-7] (2021)	50 ppm	—	A4	184.49	Embryo/fetal dam; maternal body weight eff; CNS impair; cognitive decrements
Isooctyl alcohol [26952-21-6] (1990)	50 ppm	—	Skin	130.23	URT irr
Isophorone [78-59-1] (1995)	—	C 5 ppm	A3	138.21	Eye & URT irr; CNS impair; malaise; fatigue
Isophorone diisocyanate [4098-71-9] (1988)	0.005 ppm	—	—	222.30	Resp sens
2-Isopropoxyethanol [109-59-1] (1990)	25 ppm	—	Skin	104.15	Hematologic eff
Isopropylamine [75-31-0] (2021)	2 ppm	5 ppm	Skin	59.11	URT & ocular irr; visual impair
N-Isopropylaniline [768-52-5] (1990)	2 ppm	—	Skin; BEI_M	135.21	MeHb-emia
‡ Isopropyl ether [108-20-3] (1979)	(250 ppm)	(310 ppm)	( )	102.17	(Eye & URT irr) ( )
Isopropyl glycidyl ether [4016-14-2] (1979)	50 ppm	75 ppm	—	116.18	URT & eye irr; dermatitis
Kaolin [1332-58-7] (1996)	2 mg/m^3 (E, R)	—	A4	—	Pneumoconiosis

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Kerosene [8008-20-6; 64742-81-0]/Jet fuels, as total hydrocarbon vapor (2003)	200 mg/m^3 (P)	—	Skin; A3	Varies	Skin & URT irr; CNS impair
Ketene [463-51-4] (2020)	—	C 0.05 ppm	—	42.04	Lung dam; pulm edema; URT & eye irr
Lead [7439-92-1] and inorganic compounds, as Pb (1995)	0.05 mg/m^3	—	A3; BEI	207.20 Varies	CNS & PNS impair; hematologic eff
Lead chromate [7758-97-6], as Cr(VI) (2018)	0.0002 mg/m^3 (I)	0.0005 mg/m^3 (I)	DSEN; RSEN; A1; BEI	323.22	Lung & sinonasal cancer; resp tract irr; asthma
Lindane [58-89-9] (1996)	0.5 mg/m^3	—	Skin; A3	290.85	Liver dam; CNS impair
Lithium hydride [7580-67-8] (2015)	—	C 0.05 mg/m^3 (I)	—	7.95	Eye & resp tract irr
L.P.G. (Liquefied petroleum gas) [68476-85-7]	See Appendix F: Minimal Oxygen Content (D, EX)			—	Asphyxia
Magnesium oxide [1309-48-4] (2003)	10 mg/m^3 (I)	—	A4	40.32	URT; metal fume fever
Malathion [121-75-5] (2003)	1 mg/m^3 (IFV)	—	Skin; A4; BEI_C	330.36	Cholinesterase inhib
Maleic anhydride [108-31-6] (2014)	0.01 mg/m^3 (IFV)	—	DSEN; RSEN; A4	98.06	Resp sens
Manganese [7439-96-5], elemental and inorganic compounds, as Mn (2013)	0.02 mg/m^3 (R) 0.1 mg/m^3 (I)	—	A4	54.94 Varies	CNS impair
Manganese cyclopentadienyl tricarbonyl [12079-65-1], as Mn (1992)	0.1 mg/m^3	—	Skin	204.10	Skin irr; CNS impair

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Mercury [7439-97-6], alkyl compounds, as Hg (1992)	0.01 mg/m^3	0.03 mg/m^3	Skin	Varies	CNS & PNS impair; kidney dam
Mercury [7439-97-6], all forms except alkyl, as Hg (1994)				200.59	
Aryl compounds	0.1 mg/m^3	—	Skin	Varies	CNS impair; kidney dam
Elemental and inorganic forms	0.025 mg/m^3	—	Skin; A4; BEI	Varies	CNS impair; kidney dam
Mesityl oxide [141-79-7] (1992)	15 ppm	25 ppm	—	98.14	Eye & URT irr; CNS impair
Methacrylic acid [79-41-4] (1992)	20 ppm	—	—	86.09	Skin & eye irr
Methane [74-82-8]	*See* Appendix F: Minimal Oxygen Content (D, EX)			16.04	Asphyxia
Methanol [67-56-1] (2009)	200 ppm	250 ppm	Skin; BEI_C	32.04	Headache; eye dam; dizziness; nausea
Methomyl [16752-77-5] (2014)	0.2 mg/m^3 (IFV)	—	Skin; A4; BEI_C	162.20	Cholinesterase inhib; male repro dam; hematologic eff
Methoxychlor [72-43-5] (1996)	10 mg/m^3	—	A4	345.65	Liver dam; CNS impair
2-Methoxyethanol [109-86-4] (2006)	0.1 ppm	—	Skin; BEI	76.09	Hematologic & repro eff
2-Methoxyethyl acetate [110-49-6] (2006)	0.1 ppm	—	Skin; BEI	118.13	Hematologic & repro eff
4-Methoxyphenol [150-76-5] (1992)	5 mg/m^3	—	—	124.15	Eye irr; skin dam
1-Methoxy-2-propanol [107-98-2] (2013)	50 ppm	100 ppm	A4	90.12	Eye & URT irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Methyl acetate [79-20-9] (2013)	200 ppm	250 ppm	—	74.08	Headache; dizziness; nausea; eye dam (degeneration of ganglion cells in the retina)
Methylacetylene [74-99-7] (2017)	1,000 ppm (EX)	—	—	40.07	CNS impair
Methylacetylene-propadiene mixture [59355-75-8] (2017)	1,000 ppm (EX)	1250 ppm (EX)	—	40.07	CNS impair
Methyl acrylate [96-33-3] (2014)	2 ppm	—	Skin; DSEN; A4	86.09	Eye, skin, & URT irr; eye dam
Methylacrylonitrile [126-98-7] (2011)	1 ppm	—	Skin; A4	67.09	CNS impair; eye & skin irr
Methylal [109-87-5] (1987)	1,000 ppm	—	—	76.10	Eye irr; CNS impair
Methylamine [74-89-5] (2013)	5 ppm	15 ppm	—	31.06	Eye, skin, & URT irr
Methyl n-amyl ketone [110-43-0] (1987)	50 ppm	—	—	114.18	Eye & skin irr
N-Methylaniline [100-61-8] (1992)	0.5 ppm	—	Skin; BEI_M	107.15	MeHb-emia; CNS impair
2-Methyl-2-butene [513-35-9] (2021)	10 ppm	—	—	70.13	Clastogenic eff
Methyl bromide [74-83-9] (1997)	1 ppm	—	Skin; A4	94.95	URT & skin irr
Methyl tert-butyl ether [1634-04-4] (2002)	50 ppm	—	A3	88.17	URT irr; kidney dam
* Methyl n-butyl ketone [591-78-6] (2023)	5 ppm	10 ppm	Skin	100.16	Peripheral neuropathy; testicular dam

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Methyl chloride [74-87-3] (1996)	50 ppm	100 ppm	Skin; A4	50.49	CNS impair; liver, kidney, & testicular dam; teratogenic eff
Methyl chloroform [71-55-6] (1996)	350 ppm	450 ppm	A4; BEI	133.42	CNS impair; liver dam
* Methylcyclohexane [108-87-2] (2023)	100 ppm	—	—	98.19	Kidney dam
Methylcyclohexanol [25639-42-3] (2004)	50 ppm	—	—	114.19	URT & eye irr
Methylcyclohexanone, all isomers [583-60-8; 589-92-4; 591-24-2; 1331-22-2] (2020)	20 ppm	—	—	112.17	Liver eff; CNS impair
2-Methylcyclopentadienyl manganese tricarbonyl [12108-13-3], as Mn (1986)	0.2 mg/m^3	—	Skin	218.10	CNS impair; lung, liver, & kidney dam
Methyl demeton [8022-00-2] (2007)	0.05 mg/m^3 (IFV)	—	Skin; BEI_C	230.30	Cholinesterase inhib
Methylene bisphenyl isocyanate [101-68-8] (1988)	0.005 ppm	—	—	250.26	Resp sens
4,4'-Methylene bis(2-chloroaniline) [101-14-4] (2018)	0.01 ppm (IFV)	—	Skin; A2; BEI	267.17	Bladder cancer; MeHb-emia
Methylene bis(4-cyclohexylisocyanate) [5124-30-1] (1988)	0.005 ppm	—	—	262.35	Resp sens; LRT irr
4,4'-Methylenedianiline [101-77-9] (1995)	0.1 ppm	—	Skin; A3	198.26	Liver dam
* Methyl ethyl ketone [78-93-3] (2023)	75 ppm	150 ppm	Skin; BEI	72.11	Embryo/fetal dam; URT irr; headache; dizziness

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Methyl ethyl ketone peroxide [1338-23-4] (1992)	—	C 0.2 ppm	—	176.24	Eye & skin irr; liver & kidney dam
Methyl formate [107-31-3] (2015)	50 ppm	100 ppm	Skin	60.05	CNS impair; URT irr; eye dam
Methylhydrazine [60-34-4] (1995)	0.01 ppm	—	Skin; A3	46.07	URT & eye irr; lung cancer; liver dam
Methyl iodide [74-88-4] (1996)	2 ppm	—	Skin	141.95	Eye dam; CNS impair
Methyl isoamyl ketone [110-12-3] (2013)	20 ppm	50 ppm	—	114.20	CNS impair; URT irr
Methyl isobutyl carbinol [108-11-2] (2020)	20 ppm	40 ppm	—	102.18	URT & eye irr; dizziness; headache
Methyl isobutyl ketone [108-10-1] (2010)	20 ppm	75 ppm	A3; BEI	100.16	URT irr; dizziness; headache
Methyl isocyanate [624-83-9] (2014)	0.02 ppm	0.06 ppm	Skin; DSEN	57.05	URT & eye irr
Methyl isopropyl ketone [563-80-4] (2011)	20 ppm	—	—	86.14	Embryo/fetal dam; neonatal toxicity
Methyl mercaptan [74-93-1] (2004)	0.5 ppm	—	—	48.11	Liver dam
Methyl methacrylate [80-62-6] (2015)	50 ppm	100 ppm	DSEN; A4	100.13	URT & eye irr; body weight eff; pulm edema
Methylnaphthalene, all isomers [1321-94-4; 90-12-0; 91-57-6] (2022)	0.05 ppm SL 3 mg/100 cm^2	— —	Skin; A4	142.20	URT irr; lung dam; liver eff

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Methyl parathion [298-00-0] (2009)	0.02 mg/m^3 (IFV)	—	Skin; A4; BEI_C	263.20	Cholinesterase inhib
Methyl propyl ketone [107-87-9] (2007)	—	150 ppm	—	86.17	Pulm func; eye irr
Methyl silicate [681-84-5] (1986)	1 ppm	—	—	152.22	URT irr; eye dam
α-Methylstyrene [98-83-9] (2010)	10 ppm	—	A3	118.18	URT irr; kidney & female repro dam
Methyltetrahydrophthalic anhydride isomers [3425-89-6; 5333-84-6; 11070-44-3; 19438-63-2; 19438-64-3; 26590-20-5; 42498-58-8] (2019)	0.07 ppb SL 0.7 mg/100 cm^2	0.3 ppb	Skin; DSEN; RSEN	166.70	Resp sens
Methyl vinyl ketone [78-94-4] (2019)	—	C 0.01 ppm	—	70.10	Upper resp dam; leukopenia
Metribuzin [21087-64-9] (1996)	5 mg/m^3	—	A4	214.28	Liver dam; hematologic eff
Mevinphos [7786-34-7] (2003)	0.01 mg/m^3 (IFV)	—	Skin; A4; BEI_C	224.16	Cholinesterase inhib
Mica [12001-26-2] (2020)	0.1 mg/m^3 (R)	—	—	—	Pneumoconiosis
Mineral oil, excluding metal working fluids (2010)				Varies	URT irr
Pure, highly and severely refined	5 mg/m^3 (I)	—	A4		
Poorly and mildly refined	— (L)	—	A2		

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Molybdenum [7439-98-7], as Mo				95.95	LRT irr
Soluble compounds (2003)	0.5 mg/m^3 (R)	—	A3		
Metal and insoluble compounds (2001)	10 mg/m^3 (I)	—	—		
	3 mg/m^3 (R)	—	—		
Monochloroacetic acid [79-11-8] (2006)	0.5 ppm (IFV)	—	Skin; A4	94.50	URT irr
Monocrotophos [6923-22-4] (2002)	0.05 mg/m^3 (IFV)	—	Skin; A4; BEI_C	223.16	Cholinesterase inhib
Monomethylformamide [123-39-7] (2019)	1 ppm	—	Skin	59.07	Embryo/fetal & liver dam; teratogenic eff
Morpholine [110-91-8] (1996)	20 ppm	—	Skin; A4	87.12	Eye dam; URT irr
Naled [300-76-5] (2014)	0.1 mg/m^3 (IFV)	—	Skin; DSEN; A4; BEI_C	380.79	Cholinesterase inhib
Naphthalene [91-20-3] (2014)	10 ppm	—	Skin; A3; BEI	128.19	URT irr; cataracts; hemolytic anemia
β-Naphthylamine [91-59-8] (1987)	— (L)	—	A1	143.18	Bladder cancer
Natural gas [8006-14-2]	*See* Appendix F: Minimal Oxygen Content (D, EX)			—	Asphyxia
Natural rubber latex [9006-04-6], as inhalable allergenic proteins (2014)	0.0001 mg/m^3 (I)	—	Skin; DSEN; RSEN	Varies	Resp sens
Neon [7440-01-9]	See Appendix F: Minimal Oxygen Content (D)			20.18	Asphyxia

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Nickel [7440-02-0] and inorganic compounds including Nickel subsulfide, as Ni (1998)					
Elemental [7440-02-0]	1.5 mg/m^3 (I)	—	A5; BEI	58.71	Dermatitis; pneumoconiosis
Soluble inorganic compounds (NOS)	0.1 mg/m^3 (I)	—	A4; BEI	Varies	Lung dam; nasal cancer
Insoluble inorganic compounds (NOS)	0.2 mg/m^3 (I)	—	A1; BEI	Varies	Lung cancer
Nickel subsulfide [12035-72-2], as Ni	0.1 mg/m^3 (I)	—	A1; BEI	240.19	Lung cancer
Nickel carbonyl [13463-39-3], as Ni (2014)	—	C 0.05 ppm	A3	170.73	Lung irr
Nicotine [54-11-5] (1992)	0.5 mg/m^3	—	Skin	162.23	GI dam; CNS impair; card impair
Nitrapyrin [1929-82-4] (2019)	10 mg/m^3 (IFV)	20 mg/m^3 (IFV)	A4	230.93	Liver dam
‡ Nitric acid [7697-37-2] (1997)	(2 ppm)	(4 ppm)	( )	63.02	(URT & eye irr; dental erosion)
Nitric oxide [10102-43-9] (1992)	25 ppm	—	BEI_M	30.01	Hypoxia/cyanosis; nitrosyl-Hb form; URT irr
p-Nitroaniline [100-01-6] (1996)	3 mg/m^3	—	Skin; A4; BEI_M	138.12	MeHb-emia; liver dam; eye irr
Nitrobenzene [98-95-3] (1996)	1 ppm	—	Skin; A3; BEI_M	123.11	MeHb-emia
p-Nitrochlorobenzene [100-00-5] (2008)	0.1 ppm	—	Skin; A3; BEI_M	157.56	MeHb-emia
4-Nitrodiphenyl [92-93-3] (1996)	— (L)	—	Skin; A2	199.20	Bladder cancer
Nitroethane [79-24-3] (1986)	100 ppm	—	—	75.07	URT irr; CNS impair; liver dam

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Nitrogen [7727-37-9]	See Appendix F: Minimal Oxygen Content (D)			14.01	Asphyxia
Nitrogen dioxide [10102-44-0] (2012)	0.2 ppm	—	A4	46.01	LRT irr
Nitrogen trifluoride [7783-54-2] (1992)	10 ppm	—	BEI_M	71.00	MeHb-emia; liver & kidney dam
Nitroglycerin [55-63-0] (1985)	0.05 ppm	—	Skin	227.09	Vasodilation
Nitromethane [75-52-5] (2000)	20 ppm	—	A3	61.04	Thyroid eff; URT irr; lung dam
1-Nitropropane [108-03-2] (1995)	25 ppm	—	A4	89.09	URT & eye irr; liver dam
2-Nitropropane [79-46-9] (1995)	10 ppm	—	A3	89.09	Liver dam; liver cancer
N-Nitrosodimethylamine [62-75-9] (1995)	— (L)	—	Skin; A3	74.08	Liver & kidney cancer; liver dam
Nitrotoluene, isomers [88-72-2; 99-08-1; 99-99-0] (1992)	2 ppm	—	Skin; BEI_M	137.13	MeHb-emia
5-Nitro-o-toluidine [99-55-8] (2019)	1 mg/m^3 (IFV)	—	A3	152.16	Liver dam
Nitrous oxide [10024-97-2] (1995)	50 ppm	—	A4	44.02	CNS impair; hematologic eff; embryo/fetal dam
Nonane [111-84-2] (2012)	200 ppm	—	—	128.26	CNS impair
Octachloronaphthalene [2234-13-1] (1976)	0.1 mg/m^3	0.3 mg/m^3	Skin	403.74	Liver dam
Octane [111-65-9], all isomers (1999)	300 ppm	—	—	114.22	URT irr
Osmium tetroxide [20816-12-0], as Os (1979)	0.0002 ppm	0.0006 ppm	—	254.20	Eye, URT, & skin irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Oxalic acid, anhydrous [144-62-7] and dihydrate [6153-56-6] (2015)	1 mg/m^3	2 mg/m^3	—	90.04 (anhy) 126.00 (dihy)	URT, eye, & skin irr
p,p'-Oxybis(benzenesulfonyl hydrazide) [80-51-3] (2000)	0.1 mg/m^3 (I)	—	—	358.40	Teratogenic eff
Oxygen difluoride [7783-41-7] (1983)	—	C 0.05 ppm	—	54.00	Headache; pulm edema; URT irr
Ozone [10028-15-6] (1999)				48.00	Pulm func
Heavy work	0.05 ppm	—	A4		
Moderate work	0.08 ppm	—	A4		
Light work	0.10 ppm	—	A4		
Heavy, moderate, or light workloads (≤ 2 hours)	0.20 ppm	—	A4		
Paraffin wax fume [8002-74-2] (1987)	2 mg/m^3	—	—	—	URT irr; nausea
Paraquat [4685-14-7], as the cation (2018)	0.05 mg/m^3 (I)	—	Skin; A4	257.18	Lung dam; URT irr
‡ Parathion [56-38-2] (2003)	0.05 mg/m^3 (IFV) ( )	—	Skin; (A4); BEIc	291.27	Cholinesterase inhib
Particles (insoluble or poorly soluble) not otherwise specified		See Appendix B			
* Pentaborane [19624-22-7] (2023)	—	C 0.01 ppm	Skin	63.17	CNS toxicity
Pentachloronaphthalene [1321-64-8] (1984)	0.5 mg/m^3 (IFV)	—	Skin	300.40	Liver dam; chloracne

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Pentachloronitrobenzene [82-68-8] (1996)	0.5 mg/m^3	—	A4	295.36	Liver dam
Pentachlorophenol [87-86-5] (2014)	0.5 mg/m^3 (IFV)	1 mg/m^3 (IFV)	Skin; A3; BEI	266.35	URT & eye irr; CNS & card impair
Pentaerythritol [115-77-5] (2013)	10 mg/m^3	—	—	136.15	GI irr
Pentane, all isomers [78-78-4; 109-66-0; 463-82-1] (2014)	1,000 ppm	—	—	72.15	Narcosis; resp tract irr
2,4-Pentanedione [123-54-6] (2011)	25 ppm	—	Skin	100.12	Neurotoxicity; CNS impair
Pentyl acetate, all isomers [123-92-2; 620-11-1; 624-41-9; 625-16-1; 626-38-0; 628-63-7] (2000)	50 ppm	100 ppm	—	130.20	URT irr
Peracetic acid [79-21-0] (2014)	—	0.4 ppm (IFV)	A4	76.05	URT, eye, & skin irr
Perchloromethyl mercaptan [594-42-3] (1988)	0.1 ppm	—	—	185.87	Eye & URT irr
Perchloryl fluoride [7616-94-6] (2020)	0.5 ppm	—	—	102.45	MeHb-emia; fluorosis
Perfluorobutyl ethylene [19430-93-4] (2004)	100 ppm	—	—	246.10	Hematologic eff
Perfluoroisobutylene [382-21-8] (1992)	—	C 0.01 ppm	—	200.04	URT irr; hematologic eff
Persulfates, as persulfate [7727-21-1; 7727-54-0; 7775-27-1] (2006)	0.1 mg/m^3	—	—	Varies	Skin irr
Phenol [108-95-2] (1996)	5 ppm	—	Skin; A4; BEI	94.11	URT irr; lung dam; CNS impair

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Phenothiazine [92-84-2] (2022)	0.5 mg/m^3 (I)	—	Skin; DSEN; A4	199.27	Phototoxicity; liver, bone marrow, & spleen toxicity; anemia
N-Phenyl-b-naphthylamine [135-88-6] (1996)	— (L)	—	A4	219.29	Cancer
m-Phenylenediamine [108-45-2] (1996)	0.1 mg/m^3	—	A4	108.05	Liver dam; skin irr
o-Phenylenediamine [95-54-5] (1995)	0.1 mg/m^3	—	A3	108.05	Anemia
p-Phenylenediamine [106-50-3] (1996)	0.1 mg/m^3	—	A4	108.05	URT irr; skin sens
Phenyl ether [101-84-8] (1979)	1 ppm (V)	2 ppm (V)	—	170.20	URT & eye irr; nausea
* Phenylethyl alcohol [60-12-8] (2023)	0.5 ppm	—	Skin	122.2	Embryo/fetal dam
Phenyl glycidyl ether [122-60-1] (2014)	0.1 ppm	—	Skin; DSEN; A3	150.17	Testicular dam
Phenylhydrazine [100-63-0] (1996)	0.1 ppm	—	Skin; A3	108.14	Anemia; URT & skin irr
Phenyl isocyanate [103-71-9] (2015)	0.005 ppm	0.015 ppm	Skin; DSEN; RSEN	119.10	URT irr
Phenyl mercaptan [108-98-5] (2004)	0.1 ppm	—	Skin	110.18	CNS impair; eye & skin irr
Phenylphosphine [638-21-1] (1992)	—	C 0.05 ppm	—	110.10	Dermatitis; hematologic eff; testicular dam
Phorate [298-02-2] (2005)	0.05 mg/m^3 (IFV)	—	Skin; A4; BEI_C	260.40	Cholinesterase inhib

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Phosgene [75-44-5] (2021)		C 0.02 ppm	—	98.92	URT irr; pulm edema; emphysema
Phosphine [7803-51-2] (2019)	0.05 ppm	C 0.15 ppm	A4	34.00	Resp tract irr; pulm edema
Phosphoric acid [7664-38-2] (1992)	1 mg/m^3	3 mg/m^3	—	98.00	URT, eye, & skin irr
Phosphorus (yellow) [12185-10-3] (2003)	0.1 mg/m^3	—	—	123.92	LRT, URT, & GI irr; liver dam
Phosphorus oxychloride [10025-87-3] (1990)	0.1 ppm	—	—	153.35	URT irr
Phosphorus pentachloride [10026-13-8] (1985)	0.1 ppm	—	—	208.24	URT & eye irr
Phosphorus pentasulfide [1314-80-3] (1992)	1 mg/m^3	3 mg/m^3	—	222.29	URT irr
Phosphorus trichloride [7719-12-2] (1992)	0.2 ppm	0.5 ppm	—	137.35	URT, eye, & skin irr
o-Phthalaldehyde [643-79-8] (2019)	SL 25 µg/100 cm^2	C 0.1 ppb (V)	Skin; DSEN; RSEN	134.10	Eye, skin & resp tract irr; resp sens; anaphylaxis
* Phthalic anhydride [85-44-9] (2023)	0.002 mg/m^3 (IFV) SL 0.05 mg/100 cm^2	0.005 mg/m^3 (IFV)	Skin; DSEN; RSEN; A4	148.12	Resp and dermal sens; asthma
m-Phthalodinitrile [626-17-5] (2009)	5 mg/m^3 (IFV)	—	—	128.14	Eye & URT irr
o-Phthalodinitrile [91-15-6] (2012)	1 mg/m^3 (IFV)	—	—	128.13	CNS convul; body weight eff

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Picloram [1918-02-1] (1996)	10 mg/m^3	—	A4	241.48	Liver & kidney dam
Picric acid [88-89-1] (1992)	0.1 mg/m^3	—	—	229.11	Skin sens; dermatitis; eye irr
Pindone [83-26-1] (1992)	0.1 mg/m^3	—	—	230.25	Coagulation
Piperazine and salts [110-85-0], as piperazine (2014)	0.03 ppm (IFV)	—	DSEN; RSEN; A4	86.14	Resp sens; asthma
Platinum [7440-06-4], and soluble salts (1981)					
Metal	1 mg/m^3	—	—	195.09	—
Soluble salts, as Pt	0.002 mg/m^3	—	—	Varies	Asthma; URT irr
Polyvinyl chloride [9002-86-2] (2008)	1 mg/m^3 (R)	—	A4	Varies	Pneumoconiosis; LRT irr; pulm func changes
Portland cement [65997-15-1] (2010)	1 mg/m^3 (E, R)	—	A4	—	Pulm func; resp symptoms; asthma
Potassium hydroxide [1310-58-3] (1992)	—	C 2 mg/m^3	—	56.10	URT, eye, & skin irr
Prometon [1610-18-0] (2021)	0.5 mg/m^3 (I)	—	A4	225.29	Decreased body weight
Prometryn [7287-19-6] (2021)	1 mg/m^3 (I)	—	A4	241.37	Liver & kidney dam; bone marrow eff; maternal/fetal toxicity
Propane [74-98-6]	See Appendix F: Minimal Oxygen Content (D, EX)			44.10	Asphyxia
Propane sultone [1120-71-4] (2006)	— (L)	—	A3	122.14	Cancer
n-Propanol (n-Propyl alcohol) [71-23-8] (2007)	100 ppm	—	A4	60.09	Eye & URT irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
2-Propanol [67-63-0] (2001)	200 ppm	400 ppm	A4; BEI	60.09	Eye & URT irr; CNS impair
Propargyl alcohol [107-19-7] (1992)	1 ppm	—	Skin	56.06	Eye irr; liver & kidney dam
β-Propiolactone [57-57-8] (1995)	0.5 ppm	—	A3	72.06	Skin cancer; URT irr
Propionaldehyde [123-38-6] (2002)	20 ppm	—	—	58.10	URT irr
Propionic acid [79-09-4] (1990)	10 ppm	—	—	74.08	Eye, skin, & URT irr
Propoxur [114-26-1] (2016)	0.5 mg/m^3 (IFV)	—	A3; BEI_C	209.24	Cholinesterase inhib
Propyl acetate isomers [108-21-4; 109-60-4] (2018)	100 ppm	150 ppm	—	102.13	URT & eye irr; CNS impair
Propylene [115-07-1] (2006)	500 ppm	—	A4	42.08	Asphyxia; URT irr
Propylene dichloride [78-87-5] (2014)	10 ppm	—	DSEN; A4	112.99	URT irr; body weight eff
Propylene glycol dinitrate [6423-43-4] (2022)	SL 0.02 mg/100 cm^2	0.01 ppm	Skin; BEI_M	166.09	Vasodilation; headache; hypotension; cerebrovascular & cardiovascular disease
Propylene glycol ethyl ether [1569-02-4] (2019)	50 ppm	200 ppm	Skin	104.17	CNS impair; eye & URT irr
Propylene oxide [75-56-9] (2014)	2 ppm	—	DSEN; A3	58.08	Eye & URT irr
Propyleneimine [75-55-8] (2009)	0.2 ppm	0.4 ppm	Skin; A3	57.09	URT irr; kidney dam
n-Propyl nitrate [627-13-4] (2022)	5 ppm	—	BEI_M	105.09	Anemia; MeHb-emia

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Pyrethrum [8003-34-7] (1996)	5 mg/m^3	—	A4	345 (avg.)	Liver dam; LRT irr
Pyridine [110-86-1] (2004)	1 ppm	—	A3	79.10	Skin irr; liver & kidney dam
Resin acids, as total resin acids [8050-09-7] (2020)	0.001 mg/m^3 (I)	—	DSEN; RSEN	—	Asthma; resp & eye irr; dermal & resp sens
Resorcinol [108-46-3] (1996)	10 ppm	20 ppm	A4	110.11	Eye & skin irr
Rhodium [7440-16-6], as Rh (1996)				102.91	
Metal and Insoluble compounds	1 mg/m^3	—	A4	Varies	Metal = URT irr; Insoluble = LRT irr
Soluble compounds	0.01 mg/m^3	—	A4	Varies	Asthma
Ronnel [299-84-3] (2006)	5 mg/m^3 (IFV)	—	A4; BEI_C	321.57	Cholinesterase inhib
Rotenone (commercial) [83-79-4] (1996)	5 mg/m^3	—	A4	391.41	URT & eye irr; CNS impair
Selenium [7782-49-2] and compounds, as Se (1992)	0.2 mg/m^3	—	—	78.96	Eye & URT irr
Selenium hexafluoride [7783-79-1], as Se (2001)	0.05 ppm	—	—	192.96	Pulm edema
Sesone [136-78-7] (1996)	10 mg/m^3	—	A4	309.13	GI irr
* Sevoflurane [28523-86-6] (2023)	50 ppm	—	—	200.05	CNS impair
Silica, crystalline — a quartz [1317-95-9; 14808-60-7] and cristobalite [14464-46-1] (2010)	0.025 mg/m^3 (R)	—	A2	60.09	Pulm fibrosis; lung cancer

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Silicon carbide [409-21-2] (2022)	—	—	—	40.10	
Nonfibrous	10 mg/m^3 (I) 3 mg/m^3 (R)	—	—		Pulm dam
Fibrous (including whiskers)	0.1 f/cc (F)	—	A2		Lung fibrosis; cancer
Silicon tetrahydride [7803-62-5] (2015)	5 ppm	—	—	32.12	URT irr
Silver [7440-22-4], and compounds (1992)					Argyria
Metal, dust and fume	0.1 mg/m^3	—	—	107.87	
Soluble compounds, as Ag	0.01 mg/m^3	—	—	Varies	
Simazine [122-34-9] (2016)	0.5 mg/m^3 (I)	—	A3	201.60	Hematologic eff
Sodium azide [26628-22-8] (1996)				65.02	Card impair; lung dam
as Sodium azide	—	C 0.29 mg/m^3	A4		
as Hydrazoic acid vapor	—	C 0.11 ppm	A4		
Sodium bisulfite [7631-90-5] (1996)	5 mg/m^3	—	A4	104.07	Skin, eye, & URT irr
Sodium fluoroacetate [62-74-8] (1994)	0.05 mg/m^3	—	Skin	100.02	CNS impair; card impair; nausea
Sodium hydroxide [1310-73-2] (1992)	—	C 2 mg/m^3	—	40.01	URT, eye, & skin irr
Sodium metabisulfite [7681-57-4] (1996)	5 mg/m^3	—	A4	190.13	URT irr
Starch [9005-25-8] (1996)	10 mg/m^3	—	A4	—	Dermatitis

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Stearates[J] [57-11-4; 557-04-0; 557-05-1; 822-16-2] (2017)	10 mg/m^3 (I) 3 mg/m^3 (R)	—	A4	Varies	LRT irr
Stoddard solvent [8052-41-3] (1987)	100 ppm	—	—	140.00	Eye, skin, & kidney dam; nausea; CNS impair
Strychnine [57-24-9] (1992)	0.15 mg/m^3	—	—	334.40	CNS impair
Styrene [100-42-5] (2020)	10 ppm	20 ppm	OTO; A3; BEI	104.15	CNS & hearing impair; URT irr; peripheral neuropathy; visual disorders
Styrene oxide [96-09-3] (2020)	1 ppm	—	Skin; DSEN; A3	120.15	URT irr; blood changes
Subtilisins [1395-21-7; 9014-01-1], as 100% crystalline active pure enzyme (2007)	—	C 0.00006 mg/m^3	—	—	Asthma; skin, URT, & LRT irr
Sucrose [57-50-1] (1995)	10 mg/m^3	—	A4	342.30	Dental erosion
Sulfometuron methyl [74222-97-2] (2019)	5 mg/m^3 (IFV)	—	A4	364.38	Hematologic eff
Sulfotepp [3689-24-5] (2005)	0.1 mg/m^3 (IFV)	—	Skin; A4; BEI$_C$	322.30	Cholinesterase inhib
Sulfoxaflor [946578-00-3] (2019)	0.1 mg/m^3 (I)	—	A3	277.30	Liver & testicular dam
Sulfur dioxide [7446-09-5] (2009)	—	0.25 ppm	A4	64.07	Pulm func; LRT irr
Sulfur hexafluoride [2551-62-4] (1986)	1,000 ppm	—	—	146.07	Asphyxia

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Sulfur monochloride [10025-67-9] (1986)	—	C 1 ppm	—	135.03	Eye, skin, & URT irr
Sulfur pentafluoride [5714-22-7] (2020)	—	C 0.001 ppm	—	254.11	Pulm edema
Sulfur tetrafluoride [7783-60-0] (1992)	—	C 0.1 ppm	—	108.07	Eye & URT irr; lung dam
Sulfuric acid [7664-93-9] (2004)	0.2 mg/m^3 (T)	—	A2 (M)	98.08	Pulm func
Sulfuryl fluoride [2699-79-8] (1992)	5 ppm	10 ppm	—	102.07	CNS impair
Sulprofos [35400-43-2] (2009)	0.1 mg/m^3 (IFV)	—	Skin; A4; BEI_C	322.43	Cholinesterase inhib
Synthetic vitreous fibers (2001)					
Continuous filament glass fibers	1 f/cc (F)	—	A4	—	URT irr
Continuous filament glass fibers	5 mg/m^3 (I)	—	A4	—	URT irr
Glass wool fibers	1 f/cc (F)	—	A3	—	Skin & mucous membrane irr
Rock wool fibers	1 f/cc (F)	—	A3	—	Skin & mucous membrane irr
Slag wool fibers	1 f/cc (F)	—	A3	—	Skin & mucous membrane irr
Special purpose glass fibers	1 f/cc (F)	—	A3	—	Skin & mucous membrane irr
Refractory ceramic fibers	0.2 f/cc (F)	—	A2	—	Pulm fibrosis; pulm func
2,4,5-T [93-76-5] (1996)	10 mg/m^3	—	A4	255.49	PNS impair
Talc [14807-96-6] (2010)					
Containing no asbestos fibers	2 mg/m^3 (E, R)	—	A4	—	Pulm fibrosis; pulm func
Containing asbestos fibers	Use Asbestos TLV	—	A1	—	

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Tellurium [13494-80-9] and compounds (NOS), as Te, excluding hydrogen telluride (1992)	0.1 mg/m^3	—	—	127.60	Halitosis
Tellurium hexafluoride [7783-80-4], as Te (1992)	0.02 ppm	—	—	241.61	LRT irr
Temephos [3383-96-8] (2019)	1 mg/m^3 (I)	—	Skin; A4; BEI$_C$	466.46	Cholinesterase inhib
Terbufos [13071-79-9] (2002)	0.01 mg/m^3 (IFV)	—	Skin; A4; BEI$_C$	288.45	Cholinesterase inhib
Terephthalic acid [100-21-0] (1993)	10 mg/m^3	—	—	166.13	—
Terphenyls (o-, m-, p- isomers) [26140-60-3] (1980)	—	C 5 mg/m^3	—	230.31	URT & eye irr
1,1,2,2-Tetrabromoethane [79-27-6] (2019)	0.1 ppm	—	—	345.70	Eye & URT irr; pulm edema; liver dam
1,1,1,2-Tetrachloro-2,2-difluoroethane [76-11-9] (2008)	100 ppm	—	—	203.83	Liver & kidney dam; CNS impair
1,1,2,2-Tetrachloro-1,2-difluoroethane [76-12-0] (2008)	50 ppm	—	—	203.83	Liver & kidney dam; CNS impair
1,1,2,2-Tetrachloroethane [79-34-5] (1997)	1 ppm	—	Skin; A3	167.86	Liver dam
Tetrachloroethylene [127-18-4] (2001)	25 ppm	100 ppm	A3; BEI	165.80	CNS impair
Tetrachloronaphthalene [1335-88-2] (1992)	2 mg/m^3	—	—	265.96	Liver dam
Tetrachlorvinphos [22248-79-9; 22350-76-1; 961-11-5] (2022)	0.5 mg/m^3 (I)	—	Skin; DSEN; A3; BEI$_C$	365.96	Liver & kidney eff; cholinesterase inhib; thyroid eff

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Tetraethyl lead [78-00-2], as Pb (1996)	0.1 mg/m^3	—	Skin; A4	323.45	CNS impair
Tetraethyl pyrophosphate [107-49-3] (2007)	0.01 mg/m^3 (IFV)	—	Skin; BEI_C	290.20	Cholinesterase inhib
Tetrafluoroethylene [116-14-3] (2000)	2 ppm	—	A3	100.20	Kidney & liver dam; liver & kidney cancer
Tetrahydrofuran [109-99-9] (2005)	50 ppm	100 ppm	Skin; A3; BEI	72.10	URT irr; CNS impair; kidney dam
Tetrakis (hydroxymethyl) phosphonium salts (2014)					Liver dam
Tetrakis (hydroxymethyl) phosphonium chloride [124-64-1]	2 mg/m^3	—	DSEN; A4	190.56	
Tetrakis (hydroxymethyl) phosphonium sulfate [55566-30-8]	2 mg/m^3	—	DSEN; A4	406.26	
Tetramethyl lead [75-74-1], as Pb (1992)	0.15 mg/m^3	—	Skin	267.33	CNS impair
Tetramethyl succinonitrile [3333-52-6] (2019)	0.5 mg/m^3 (IFV)	—	Skin	136.20	Hypoglycemia; convul
Tetranitromethane [509-14-8] (1995)	0.005 ppm	—	A3	196.04	Eye & URT irr; URT cancer
Tetryl [479-45-8] (1988)	1.5 mg/m^3	—	—	287.15	URT irr
Thallium [7440-28-0] and compounds, as Tl (2010)	0.02 mg/m^3 (I)	—	Skin	204.37 Varies	GI dam; peripheral neuropathy
Thiacloprid [111988-49-9] (2019)	0.2 mg/m^3 (I)	—	Skin; A3	252.72	Liver dam; thyroid & CNS eff; cancer
4,4'-Thiobis(6-tert-butyl-m-cresol) [96-69-5] (2011)	1 mg/m^3 (I)	—	A4	358.52	URT irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Thiodicarb [59669-26-0] (2020)	0.1 mg/m^3 (IFV)	—	DSEN; A3	354.50	Acetylcholinesterase inhib
Thioglycolic acid [68-11-1] and salts (2018)	1 ppm	—	Skin; DSEN	92.12	Eye & resp irr
Thionyl chloride [7719-09-7] (2010)	—	C 0.2 ppm	—	118.98	URT irr
Thiram [137-26-8] (2014)	0.05 mg/m^3 (IFV)	—	DSEN; A4	240.44	Body weight & hematologic eff
Tin [7440-31-5] and inorganic compounds [18282-10-5; 21651-19-4], excluding Tin hydride and Indium tin oxide, as Sn (2019)	2 mg/m^3 (I)	—	—	118.69 Varies	Pneumoconiosis
Tin [7440-31-5], organic compounds, as Sn (1996)	0.1 mg/m^3	0.2 mg/m^3	Skin; A4	Varies	Eye & URT irr; headache; nausea; CNS & immune eff
Titanium dioxide [13463-67-7] (2021)					
Nanoscale particles	0.2 mg/m^3 (R)	—	A3	79.90	LRT irr; pneumoconiosis
Finescale particles	2.5 mg/m^3 (R)	—	A3	79.90	LRT irr; pneumoconiosis
Titanium tetrachloride, as HCl [7550-45-0] (2020)	—	C 0.5 ppm	A4	189.68	URT irr; URT dam
o-Tolidine [119-93-7] (1992)	—	—	Skin; A3	212.28	Eye, bladder, & kidney irr; bladder cancer; MeHb-emia
Toluene [108-88-3] (2020)	20 ppm	—	OTO; A4; BEI	92.14	CNS, visual, & hearing impair; female repro system eff; pregnancy loss
Toluene diisocyanate, 2,4- or 2,6- (or as a mixture) [584-84-9; 91-08-7] (2016)	0.001 ppm (IFV)	0.005 ppm (IFV)	Skin; DSEN; RSEN; A3; BEI	174.15	Asthma; pulm func; eye irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
m-Toluidine [108-44-1] (1996)	2 ppm	—	Skin; A4; BEI_M	107.15	Eye, bladder, & kidney irr; MeHb-emia
o-Toluidine [95-53-4] (1995)	2 ppm	—	Skin; A3; BEI_M	107.15	MeHb-emia; skin, eye, kidney & bladder irr
p-Toluidine [106-49-0] (1995)	2 ppm	—	Skin; A3; BEI_M	107.15	MeHb-emia
Tributyl phosphate [126-73-8] (2013)	5 mg/m^3 (IFV)	—	A3; BEI_C	266.31	Bladder, eye, & URT irr
Trichlorfon [52-68-6] (2020)	0.1 mg/m^3 (IFV)	—	A4; DSEN; BEI_C	257.44	Cholinesterase inhib
Trichloroacetic acid [76-03-9] (2014)	0.5 ppm	—	A3	163.39	Eye & URT irr
1,2,4-Trichlorobenzene [120-82-1] (1978)	—	C 5 ppm	—	181.46	Eye & URT irr
1,1,2-Trichloroethane [79-00-5] (1995)	10 ppm	—	Skin; A3	133.41	CNS impair; liver dam
Trichloroethylene [79-01-6] (2007)	10 ppm	25 ppm	A2; BEI	131.40	CNS impair; cognitive decrements; renal toxicity
Trichlorofluoromethane [75-69-4] (1996)	—	C 1,000 ppm	A4	137.38	Card sens
Trichloronaphthalene [1321-65-9] (1986)	5 mg/m^3	—	Skin	231.51	Liver dam; chloracne
1,2,3-Trichloropropane [96-18-4] (2015)	0.005 ppm	—	A2	147.43	Cancer
1,1,2-Trichloro-1,2,2-trifluoroethane [76-13-1] (1996)	1,000 ppm	1,250 ppm	A4	187.40	CNS impair
* Triclosan [3380-34-5] (2023)	1 mg/m^3	—	Skin; A3	289.54	Hematology eff
Triethanolamine [102-71-6] (1993)	5 mg/m^3	—	—	149.22	Eye & skin irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Triethylamine [121-44-8] (2015)	0.5 ppm	1 ppm	Skin; A4	101.19	Visual impair; URT irr
Triflumizole [68694-11-1] (2021)	1 mg/m^3 (I)	—	A4; DSEN	345.75	Liver changes
Trifluorobromomethane [75-63-8] (1986)	1000 ppm	—	—	148.92	CNS & card impair
1,3,5-Triglycidyl-s-triazinetrione [2451-62-9] (1997)	0.05 mg/m^3	—	—	297.25	Male repro dam
Trimellitic anhydride [552-30-7] (2014)	0.0005 mg/m^3 (IFV)	0.002 mg/m^3 (IFV)	Skin; DSEN; RSEN	192.12	Resp sens
Trimethylamine [75-50-3] (2013)	5 ppm	15 ppm	—	59.11	URT, eye, & skin irr
Trimethyl benzene, isomers [25551-13-7, 526-73-8, 95-63-6, 108-67-8] (2021)	10 ppm	—	A4* * for 1,2,4-trimethyl benzene	120.19	CNS impair; hematologic eff
Trimethyl phosphite [121-45-9] (1986)	2 ppm	—	BEI_C	124.08	Eye irr; cholinesterase inhib
2,4,6-Trinitrotoluene [118-96-7] (2019)	0.1 mg/m^3 (IFV)	—	Skin; BEI_M	227.13	MeHb-emia; liver dam; cataract
Triorthocresyl phosphate [78-30-8] (2016)	0.02 mg/m^3 (IFV)	—	Skin; BEI_C	368.37	Neurotoxicity; cholinesterase inhib
Triphenyl phosphate [115-86-6] (1996)	3 mg/m^3	—	A4; BEI_C	326.28	Cholinesterase inhib
Tungsten [7440-33-7] and compounds, in the absence of Cobalt, as W (2017)	3 mg/m^3 (R)	—	—	183.84 Varies	Lung dam
Turpentine [8006-64-2] and selected monoterpenes [80-56-8; 127-91-3; 13466-78-9] (2014)	20 ppm	—	DSEN; A4	136.00 Varies	Lung irr

Substance [CAS No.] (Documentation date)	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Uranium (natural) [7440-61-1] (1996)				238.03	Kidney dam
Soluble and insoluble compounds, as U	0.2 mg/m^3	0.6 mg/m^3	A1; BEI	Varies	
n-Valeraldehyde [110-62-3] (1984)	50 ppm	—	—	86.13	Eye, skin, & URT irr
Vanadium pentoxide [1314-62-1], as V (2009)	0.05 mg/m^3 (I)	—	A3	181.88	URT & LRT irr
Vinyl acetate [108-05-4] (2018)	10 ppm	15 ppm	A3	86.09	URT & eye irr
Vinyl bromide [593-60-2] (1999)	0.5 ppm	—	A2	106.96	Liver cancer
Vinyl chloride [75-01-4] (1999)	1 ppm	—	A1	62.50	Lung cancer; liver dam
4-Vinyl cyclohexene [100-40-3] (1996)	0.1 ppm	—	A3	108.18	Female & male repro dam
Vinyl cyclohexene dioxide [106-87-6] (1996)	0.1 ppm	—	Skin; A3	140.18	Female & male repro dam
Vinyl fluoride [75-02-5] (1998)	1 ppm	—	A2	46.05	Liver cancer; liver dam
N-Vinyl-2-pyrrolidone [88-12-0] (2003)	0.05 ppm	—	A3	111.16	Liver dam
Vinylidene chloride [75-35-4] (1999)	5 ppm	—	A4	96.95	Liver & kidney dam
Vinylidene fluoride [75-38-7] (1998)	500 ppm	—	A4	64.04	Liver dam
Vinyltoluene [25013-15-4] (2022)	10 ppm	—	A4	118.18	URT & lung dam
Warfarin [81-81-2] (2016)	0.01 mg/m^3 (I)	—	Skin	308.32	Bleeding; teratogenic

Substance [CAS No.]	ADOPTED VALUES TWA	STEL	Notations	MW	TLV Basis
Wood dusts (2015)				NA	
Western red cedar	0.5 mg/m^3 (I)	—	DSEN; RSEN; A4		Asthma
All other species	1 mg/m^3 (I)	—	—		Pulm func; URT & LRT irr
Carcinogenicity					
Oak and beech	—	—	A1		
Birch, mahogany, teak, walnut	—	—	A2		
All other wood dusts	—	—	A4		
Xylene, all isomers [1330-20-7; 95-47-6; 106-42-3; 108-38-3] (2021)	20 ppm	—	OTO**; A4; BEI **for p-xylene and mixtures containing p-xylene	106.16	Eye & URT irr; hematologic eff; ototoxicity (for p-xylene and mixtures containing p-xylene); CNS impair
m-Xylene a,a'-diamine [1477-55-0] (2019)	—	C 0.018 ppm	Skin	136.20	Eye, skin, & GI irr
Xylidine (mixed isomers) [1300-73-8] (2002)	0.5 ppm (IFV)	—	Skin; A3; BEI_M	121.18	Liver dam; MeHb-emia
Yttrium [7440-65-5] and compounds, as Y (1988)	1 mg/m^3	—	—	88.91	Pulm fibrosis
Zinc chloride fume [7646-85-7] (1992)	1 mg/m^3	2 mg/m^3	—	136.29	LRT & URT irr
Zinc oxide [1314-13-2] (2003)	2 mg/m^3 (R)	10 mg/m^3 (R)	—	81.37	Metal fume fever
Zirconium [7440-67-7] and compounds, as Zr (1996)	5 mg/m^3	10 mg/m^3	A4	91.22	Resp irr

*2023 Adoption ‡See Notice of Intended Changes (NIC)

2024 NOTICE OF INTENDED CHANGES

These substances, with their corresponding values and notations, comprise those for which (1) a limit is proposed for the first time, (2) a change in the Adopted value is proposed, (3) retention as an NIC is proposed, or (4) withdrawal of the Documentation and adopted TLV is proposed. In each case, the proposals should be considered trial values during the period they are on the NIC. These proposals were ratified by the ACGIH Board of Directors and will remain on the NIC for a minimum of one comment period following this ratification. If the Committee neither finds nor receives any substantive data that change its scientific opinion regarding an NIC TLV, the Committee may then approve its recommendation to the ACGIH Board of Directors for adoption. If the Committee finds or receives substantive data that change its scientific opinion regarding an NIC TLV, the Committee may change its recommendation to the ACGIH Board of Directors for the matter to be either retained on or withdrawn from the NIC.

Documentation is available for each of these substances and their proposed values.

This notice provides an opportunity for comment on these proposals. Comments or suggestions should be accompanied by substantiating evidence, preferably in the form of peer-reviewed literature and forwarded in electronic format to the ACGIH Science Group at science@acgih.org. Please refer to the ACGIH TLV/BEI Development Process on the ACGIH website (acgih.org/science/tlv-bei-guidelines/policies-procedures-presentations/tlv-bei-development) for a detailed discussion covering this procedure, methods for input to ACGIH, and deadline date for receiving comments.

	2024 NOTICE OF INTENDED CHANGES				
Substance [CAS No.]	**TWA**	**STEL**	**Notations**	**MW**	**TLV Basis**
† Acrolein [107-02-8]	—	C 0.05 ppm	Skin; A3	56.06	Eye irr
† Desflurane [57041-67-5]	100 ppm	—	—	168.04	CNS impair; cognitive decrements
† Difluorodibromomethane [75-61-6]	100 ppm	—	—	209.8	Resp irr; liver dam; CNS eff
Dimethenamid-P [16351514-8]	0.2 mg/m^3 (IFV)	—	DSEN; A3	275.8	Liver dam; bile duct hyperplasia

Substance [CAS No.]	2023 NOTICE OF INTENDED CHANGES			MW	TLV Basis
	TWA	STEL	Notations		
Endotoxins [67924-63-4]	90 EU/m^3 (I)	—	A4	Species-dependent variation	Pulm func; LRT irr
† Imidacloprid [138261-41-3]	0.005 mg/m^3 (I)	—	A4	255.66	Male repro system dam; body weight eff; repro eff; neurodevelopmental impair
† Isopropyl ether [108-20-3]	20 ppm	—	A4	102.17	Embryo/fetal dam; body weight eff
Nitric acid [7697-37-2]	—	0.025 ppm (IFV)	A4	63.02	Pulm func; Pulm edema
† Parathion [56-38-2]	0.05 mg/m^3 (IFV) SL 0.5 mg/100 cm^2	—	Skin; A3; BEI_C	291.27	Cholinesterase inhib
† Propionitrile [107-12-0]	—	C 10 ppm	Skin	55.08	CNS impairment; URT infection; eye irr; pregnancy loss
Trimetacresyl phosphate [563-04-2]	0.05 mg/m^3 (IFV)	—	—	368.36	Adrenal gland & female repro system dam
† Trimethylolpropane [77-99-6]	0.5 ppm (IFV)	—	—	134.17	Neurotoxicity; developmental neurotoxicity

Substance [CAS No.] (Documentation date)	ADOPTED VALUES			MW	TLV Basis
	TWA	STEL	Notations		
Triparacresyl phosphate [78-32-0]	0.05 mg/m^3 (IFV)	—	—	368.36	Adrenal gland & female repro system dam

†2023 Revision or Addition to the Notice of Intended Changes

CHEMICAL SUBSTANCES AND OTHER ISSUES UNDER STUDY

The TLV Chemical Substances Committee solicits information, especially data, which may assist in its deliberations regarding the following substances and issues. Comments and suggestions, accompanied by substantiating evidence preferably in the form of peer-reviewed literature, should be forwarded in electronic format to the ACGIH Science Group at science@acgih.org. In addition, the Committee solicits recommendations for additional substances and issues of concern to the industrial hygiene and occupational health communities. Please refer to the ACGIH TLV/BEI Development Process found on the ACGIH website for a detailed discussion covering this procedure and methods for input to ACGIH (acgih.org/science/tlv-bei-guidelines/policies-procedures-presentations/tlv-bei-development).

The Under Study list is published each year, by February 1 and August 1, on the ACGIH website (acgih.org/science/tlv-bei-guidelines/documentation-publications-and-data/under-study) and later in the annual TLVs and BEIs book.

The substances and issues listed below are current as of December 1, 2023. *After this date, please refer to the ACGIH website (*acgih.org/science/tlv-bei-guidelines/documentation-publications-and-data/under-study*) for the up-to-date list.*

Chemical Substances

Bifenazate
1-Bromo-3-chloropropane
Carbon monoxide
Cinnamaldehyde
Copper
Copper naphthlenate
Desflurane
Dicamba
Diethyltoluamide (DEET)
Dimethyl carbamoyl chloride
Enflurane
Fluorides
Lead and inorganic compounds, as Pb
Malathion
4, 4'-Methylene bis(2-chloroaniline)
2-Methylimidazole
Metribuzin
Molybdenum
Nicotine
Nitroglycerin
Phosphorus
Propylene dichloride (1,2-Dichloropropane)
Sodium silicates
Subtilisins
Thorium dioxide
Trichloronaphthalene
1,2,3-Trichloropropane
Triclopyr
Triethanolamine
Triethylene glycol
Trimellitic anhydride
Vinylidene chloride
Vinylidene fluoride

DEFINITIONS AND NOTATIONS

Definitions

Documentation

The source publication that provides the critical evaluation of the pertinent scientific information and data with reference to literature sources upon which each TLV or BEI is based. *See* the discussion under "TLV/BEI Development Process: An Overview" found at the beginning of this book. The general outline used when preparing the Documentation may be found in the Operations Manual of the Threshold Limit Values for Chemical Substances (TLV-CS) Committee, accessible online at: acgih.org/about/volunteer-leadership/committees/committee-operations-manuals.

Minimal Oxygen Content

An oxygen (O_2)-deficient atmosphere is defined as one with an ambient pO_2 less than 132 torr.[1] The minimum requirement of 19.5% oxygen at sea level (148 torr O_2, dry air) provides an adequate amount of oxygen for most work assignments and includes a margin of safety.[2,3] Studies of pulmonary physiology suggest that the above requirements provide an adequate level of oxygen pressure in the lungs (alveolar pO_2 of 60 torr).[4-6]

Some gases and vapors, when present in high concentrations in air, act primarily as simple asphyxiants, without other significant physiologic effects. A simple asphyxiant may not be assigned a TLV because the limiting factor is the available oxygen. Atmospheres deficient in O_2 do not provide adequate warning and most simple asphyxiants are odorless. Account should be taken of this factor in limiting the concentration of the asphyxiant particularly at elevations greater than 5,000 feet where the pO_2 of the atmosphere is less than 120 torr. Several simple asphyxiants present an explosion hazard. *See* page 85 for adopted Appendix F: Minimal Oxygen Content.

Nanomaterials

Nanomaterials are objects that are 100 nm or smaller in one or more dimension. Substances composed of nanomaterials, even when agglomerated, may have greater or different toxicity than the same substance in fine or sometimes called "bulk" form. When supported by the literature, ACGIH may differentiate TLVs for nanomaterials.

Notation

A notation is a designation that appears as a component of the TLV in which specific information is listed in the column devoted to Notations.

Notice of Intended Change (NIC)

The NIC is a list of actions proposed by the TLV-CS Committee for the coming year. This Notice provides an opportunity for public comment. Values remain on

the NIC for a minimum of one comment period after they have been ratified by the ACGIH Board of Directors. The proposals should be considered trial values during the period they are on the NIC. If the Committee neither finds nor receives any substantive data that change its scientific opinion regarding an NIC TLV, the Committee may then approve its recommendation to the ACGIH Board of Directors for adoption. If the Committee finds or receives substantive data that change its scientific opinion regarding an NIC TLV, the Committee may change its recommendation to the ACGIH Board of Directors for the matter to be either retained on or withdrawn from the NIC. Values appearing in parentheses in the Adopted TLV section are to be used during the period in which a proposed change for that value or notation appears on the NIC.

Particulate Matter/Particle Size

For solid and liquid particulate matter, TLVs are expressed in terms of total particulate matter, except where the terms inhalable, thoracic, or respirable particulate matter are used. The intent of ACGIH is to replace all total particulate TLVs with inhalable, thoracic, or respirable particulate mass TLVs. Side-by-side sampling using "total" and inhalable, thoracic, or respirable sampling techniques is encouraged to aid in the replacement of current total particulate TLVs. *See* Appendix C: Particle Size-Selective Sampling Criteria for Airborne Particulate Matter, for the definitions of inhalable, thoracic, and respirable particulate matter.

Particles (insoluble or poorly soluble) Not Otherwise Specified (PNOS)

There are many insoluble particles of low toxicity for which no TLV has been established. ACGIH believes that even biologically inert, insoluble, or poorly soluble particles may have adverse effects and suggests that airborne concentrations should be kept below 3 mg/m^3, respirable particles, and 10 mg/m^3, inhalable particles, until such time as a TLV is set for a particular substance. A description of the rationale for this recommendation and the criteria for substances to which it pertains are provided in Appendix B.

TLV Basis

TLVs are derived from publicly available information summarized in their respective Documentation. Although adherence to the TLV may prevent several adverse health effects, it is not possible to list all of them in this book. The basis on which the values are established will differ from agent to agent (e.g., protection against impairment of health may be a guiding factor for some, whereas reasonable freedom from irritation, narcosis, nuisance, or other forms of stress may form the basis for others). Health impairments considered include those that shorten life expectancy, adversely affect reproductive function or developmental processes, compromise organ or tissue function, or impair the capability for resisting other toxic substances or disease processes.

The TLV Basis represents the adverse effect(s) upon which the TLV is based. The TLV Basis column in this book is intended to provide a field reference for symptoms of overexposure and as a guide for determining whether components of a mixed exposure should be considered as acting independently or additively. Use of the TLV Basis column is not a substitute

for reading the Documentation. Each Documentation is a critical component for proper use of the TLV(s) and to understand the TLV basis. A complete list of the TLV bases used by the Threshold Limit Values for Chemical Substances Committee may be found in their Operations Manual online at: (acgih.org/tlv-bei-guidelines/policies-procedures-presentations/tlv-bei-committee-operations-manuals).

Abbreviations used

card – cardiac
CNS – central nervous system
COHb-emia – carboxyhemoglobinemia
convul – convulsion
dam – damage
eff – effects
form – formation
func – function
GI – gastrointestinal
Hb – hemoglobin
impair – impairment
inhib – inhibition
irr – irritation
LRT – lower respiratory tract
MeHb-emia – methemoglobinemia
PNS – peripheral nervous system
pulm – pulmonary
repro – reproductive
resp – respiratory
sens – sensitization
URT – upper respiratory tract

Notations/Endnotes

Biological Exposure Indices (BEIs)

The notation BEI is listed in the Notations column when a BEI (or BEIs) is (are) also recommended for the substance. Three subcategories to the BEI notation have been added to help the user identify those substances that would use only the BEI for Cholinesterase inhibiting pesticides or Methemoglobin inducers. They are as follows:

BEI_C = *See* the BEI for Cholinesterase inhibiting pesticide
BEI_M = *See* the BEI for Methemoglobin inducers
BEI_P = *See* the BEI for Polycyclic aromatic hydrocarbons (PAHs)

Biological monitoring should be instituted for such substances to evaluate the total exposure from all sources, including dermal, ingestion, or nonoccupational. *See* the BEI section in this book and the Documentation of the TLVs and BEIs for these substances.

Carcinogenicity

A carcinogen is an agent capable of inducing benign or malignant neoplasms. Evidence of carcinogenicity comes from epidemiology, toxicology, and mechanistic studies. Specific notations (i.e., A1, A2, A3, A4, and A5) are used by ACGIH to define the categories for carcinogenicity and are listed in the Notations column. *See* Appendix A for these categories and definitions and their relevance to humans in occupational settings.

Inhalable Fraction and Vapor (IFV)

The Inhalable Fraction and Vapor (IFV) endnote is used when a material exerts sufficient vapor pressure such that it may be present in both particle

and vapor phases, with each contributing a significant portion of the dose at the TLV-TWA concentration. The ratio of the Saturated Vapor Concentration (SVC) to the TLV-TWA is considered when assigning the IFV endnote. The IFV endnote is typically used for substances with an SVC/TLV ratio between 0.1 and 10.

The industrial hygienist should also consider both particle and vapor phases to assess exposures from spraying operations, from processes involving temperature changes that may affect the physical state of matter, when a significant fraction of the vapor is dissolved into or adsorbed onto particles of another substance, such as water-soluble compounds in high humidity environments.[7]

Ototoxicant

The designation OTO for hearing disorders in the Notations column highlights the potential for a chemical to cause hearing impairment alone or in combination with noise, even below 85 dBA. The OTO notation is reserved for chemicals that have been shown, through evidence from animals or humans, to adversely affect anatomical structure or auditory function, manifested as a permanent audiometric threshold shift and/or difficulties in processing sounds. Some substances appear to act synergistically with noise, whereas others may potentiate noise effects. The OTO notation is intended to focus attention, not only on engineering controls, administrative controls and PPE needed to reduce airborne concentrations, but also on other means of preventing excessive combined exposures with noise to prevent hearing disorders. Specifically, affected employees may need to be enrolled in hearing conservation and medical surveillance programs to more closely monitor auditory capacity, even when noise exposures do not exceed the TLV for Audible Sound. Please refer to the section on Ototoxicity in the TLV Documentation for Audible Sound. Also see references listed at the end of the Definitions/Notations section.[8-10]

Sensitization

The designations, DSEN and/or RSEN, in the Notations column in the *TLVs and BEIs* book refer to the potential for an agent to produce dermal and/or respiratory sensitization. RSEN and DSEN are used in place of the SEN notation when specific evidence of sensitization by that route is confirmed by human or animal data. The DSEN and RSEN notations do not imply that sensitization is the critical effect on which the TLV is based, nor do they imply that this effect is the sole basis for that agent's TLV. If sensitization data exist, they are carefully considered when recommending the TLV for the agent. TLVs that are based upon sensitization are meant to protect workers from induction of this effect. These TLVs are not intended to protect those workers who have already become sensitized.

In the workplace, respiratory or dermal exposures to sensitizing agents may occur. Similarly, sensitizers may evoke respiratory or dermal reactions. The notation does not distinguish between sensitization involving any of these tissues. The absence of a DSEN or RSEN notation does not signify that the

agent lacks the ability to produce sensitization but may reflect the paucity or inconclusiveness of scientific evidence.

Sensitization often occurs via an immunologic mechanism and should not be confused with hyperreactivity, susceptibility, or sensitivity. Initially, there may be little or no response to a sensitizing agent. However, after a person is sensitized, subsequent exposure may cause intense responses, even at low exposure concentrations (well below the TLV). These reactions may be life-threatening and may have an immediate or delayed onset. Workers who have become sensitized to a particular agent may also exhibit cross-reactivity to other agents that have similar chemical structures. A reduction in exposure to the sensitizer and its structural analogs generally reduces the frequency or severity of reactions among sensitized individuals. For some sensitized individuals, complete avoidance of exposure to the sensitizer and structural analogs provides the only means to prevent the specific immune response.

Agents that are potent sensitizers present special problems in the workplace. Respiratory and dermal exposures should be significantly reduced or eliminated through process control measures and personal protective equipment. Education and training (e.g., review of potential health effects, safe handling procedures, emergency information) are also necessary for those who work with known sensitizing agents.

For additional information regarding the sensitization potential of a particular agent, refer to the TLV Documentation for the specific agent.

Skin

The designation Skin in the Notations column refers to the potential significant contribution to the overall exposure by the cutaneous route, including mucous membranes and the eyes, by contact with vapors, liquids, and solids. Where dermal application studies have shown absorption that could cause systemic effects following exposure, a Skin notation would be considered. The Skin notation also alerts the industrial hygienist that overexposure may occur following dermal contact with liquid and aerosols, even when airborne exposures are at or below the TLV.

A Skin notation is not applied to chemicals that may cause dermal irritation. However, it may accompany a sensitizer notation for substances that cause respiratory sensitization following dermal exposure. Although not considered when assigning a Skin notation, the industrial hygienist should be aware that there are several factors that may significantly enhance potential skin absorption of a substance that otherwise has low potential for the cutaneous route of entry. Certain vehicles can act as carriers, and when pretreated on the skin or mixed with a substance can promote the transfer of the substance into the skin. In addition, the existence of some dermatologic conditions can also significantly affect the entry of substances through the skin or wound.

While relatively limited quantitative data currently exist with regard to skin absorption of gases, vapors, and liquids by workers, ACGIH recommends that the integration of data from acute dermal studies and repeated-dose dermal studies in animals and humans, along with the ability of the chemical to be absorbed, be used in deciding on the appropriateness of the Skin notation. In general, available data which suggest that the potential for absorption via

the hands and forearms during the workday could be significant, especially for chemicals with lower TLVs, could justify a Skin notation. From acute animal toxicity data, materials having a relatively low dermal LD_{50} (i.e., 1,000 mg/kg of body weight or less) would be given a Skin notation. When chemicals penetrate the skin easily (i.e., higher octanol–water partition coefficients) and where extrapolations of systemic effects from other routes of exposure suggest dermal absorption may be important in the expressed toxicity, a Skin notation would be considered. A Skin notation is not applied to chemicals that cause irritation or corrosive effects in the absence of systemic toxicity.

Substances having a Skin notation and a low TLV may present special problems for operations involving high airborne concentrations of the material, particularly under conditions where significant areas of the skin are exposed for a long period. Under these conditions, special precautions to significantly reduce or preclude skin contact may be required.

Biological monitoring should be considered to determine the relative contribution to the total dose from exposure via the dermal route. ACGIH recommends a number of adopted Biological Exposure Indices (BEIs) that provide an additional tool when assessing the total worker exposure to selected materials. For additional information, refer to *Dermal Absorption* in the "Introduction to the Biological Exposure Indices," Documentation of the BEIs,[11] and to Leung and Paustenbach.[12] Other selected readings on skin absorption and the skin notation include Sartorelli,[13] Schneider et al.,[14] Wester and Maibach,[15] Kennedy et al.,[16] Fiserova-Bergerova et al.,[17] and Scansetti et al.[18]

The use of a Skin notation is intended to alert the reader that air sampling alone is insufficient to quantify exposure accurately and that measures to prevent significant cutaneous absorption may be required.

References

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All pertinent notes relating to the material in the Chemical Substances section of this book appear in the appendices for this section or on the inside back cover.

ADOPTED APPENDICES
APPENDIX A: Carcinogenicity

ACGIH has been aware of the increasing public concern over chemicals or industrial processes that cause or contribute to increased risk of cancer in workers. More sophisticated methods of bioassay, as well as the use of sophisticated mathematical models that extrapolate the levels of risk among workers, have led to differing interpretations as to which chemicals or processes should be categorized as human carcinogens and what the maximum exposure levels should be. The categories for carcinogenicity are:

A1 — *Confirmed Human Carcinogen:* The agent is carcinogenic to humans based on the weight of evidence from epidemiologic studies.

A2 — *Suspected Human Carcinogen:* Human data are accepted as adequate in quality but are conflicting or insufficient to classify the agent as a confirmed human carcinogen; or, the agent is carcinogenic in experimental animals at dose(s), by route(s) of exposure, at site(s), of histologic type(s), or by mechanism(s) considered relevant to worker exposure. The A2 is used primarily when there is limited evidence of carcinogenicity in humans and sufficient evidence of carcinogenicity in experimental animals is supported by mechanistic evidence of key characteristics of carcinogens that are relevant to humans.

A3 — *Confirmed Animal Carcinogen with Unknown Relevance to Humans:* The agent is carcinogenic in experimental animals at a relatively high dose, by route(s) of administration, at site(s), of histologic type(s), or by mechanism(s) that may not be relevant to worker exposure. Available epidemiologic studies do not confirm an increased risk of cancer in exposed humans. Available experimental animal evidence suggests mechanisms and/or dosimetry that the agent is unlikely to cause cancer in humans except under improbable routes or levels of exposure.

A4 — *Not Classifiable as a Human Carcinogen:* Agents which cause concern that they could be carcinogenic for humans, but which cannot be assessed conclusively because of a lack of human data. *In vitro* or animal studies do not provide mechanistic evidence of key characteristics of carcinogenicity which are sufficient to classify the agent into one of the other categories.

A5 — *Not Suspected as a Human Carcinogen:* The agent is not suspected to be a human carcinogen on the basis of properly conducted epidemiologic studies in humans. These studies have sufficiently long follow-up, reliable exposure histories, sufficiently high dose, and adequate statistical power to conclude that exposure to the agent does not convey a significant risk of cancer to humans; or, the evidence suggesting a lack of carcinogenicity in experimental animals is supported by mechanistic data demonstrating a lack of the key characteristics of carcinogenicity.

Note: Substances for which no human or experimental animal carcinogenicity data are available and no strong genotoxicity data have been reported are assigned no carcinogenicity designation.

Exposure to carcinogens must be kept to a minimum. Worker exposures to A1 carcinogens without a TLV should be eliminated to the fullest extent

possible. For A1 carcinogens with a TLV and for A2 and A3 carcinogens, worker exposure by all routes should be carefully controlled to levels as low as possible below the TLV as indicated by the (L) endnote in the TLV Table.

APPENDIX B: Particles (insoluble or poorly soluble) Not Otherwise Specified (PNOS)

The goal of the TLV-CS Committee is to recommend TLVs for all substances for which there is evidence of health effects at airborne concentrations encountered in the workplace. When a sufficient body of evidence exists for a particular substance, a TLV is established. Thus, by definition the substances covered by this recommendation are those for which little data exist. The recommendation at the end of this Appendix is supplied as a guideline rather than a TLV because it is not possible to meet the standard level of evidence used to assign a TLV. In addition, the PNOS TLV and its predecessors have been misused in the past and applied to any unlisted particles rather than those meeting the criteria listed below. The recommendations in this Appendix apply to particles that:

- Do not have an applicable TLV;
- Are insoluble or poorly soluble in water (or, preferably, in aqueous lung fluid if data are available); and
- Have low toxicity (i.e., are not cytotoxic, genotoxic, or otherwise chemically reactive with lung tissue, and do not emit ionizing radiation, cause immune sensitization, or cause toxic effects other than by inflammation or the mechanism of "lung overload").

ACGIH believes that even biologically inert, insoluble, or poorly soluble particles may have adverse effects and recommends that airborne concentrations should be kept below 3 mg/m^3, respirable particles, and 10 mg/m^3, inhalable particles, until such time as a TLV is set for a particular substance.

APPENDIX C: Aerosol Size-Selective Sampling Criteria for Non–Gas/Vapor Airborne Matter

For chemical substances present in inhaled air as aerosols, a suspension of liquid or solid particles in a gas,[1] the potential hazard to the respiratory tract depends on aerosol size, mass, and/or number concentration in the air because of (1) the effects of aerosol size on the deposition site within the respiratory tract, and (2) the tendency for many occupational diseases to be associated with local deposition of material in a particular regions of the respiratory tract.

The TLV-CS Committee examines all chemical substances that present aerosol exposures in occupational environments with the objective of defining: (1) the size-fraction most closely associated for each substance with the health effect of concern, and (2) the mass concentration within that size fraction which should represent the TLV. For example, air sampling strategies for crystalline silica have evolved over time from particle counts to mass-based methods

in recognition of the well-established association between silicosis and specific respiratory tract deposition patterns.

The particle size-selective TLVs (PSS-TLVs) are expressed in 3 forms:

1. *Inhalable particulate matter TLVs* (IPM-TLVs) for materials that are hazardous when deposited anywhere in the respiratory tract.
2. *Thoracic particulate matter TLVs* (TPM-TLVs) for materials that are hazardous when deposited anywhere within the lung airways and the gas-exchange region.
3. *Respirable particulate matter TLVs* (RPM-TLVs) for materials that are hazardous when deposited in the gas-exchange region.

The 3 particulate matter fractions are defined in quantitative terms according to the following equations[2-4]:

A. IPM fraction consists of aerosol diameters that are captured with respect to the device's collection efficiency according to the following collection efficiency regardless of sampler orientation:

$$IPM\ (d_{ae}) = 0.5\ [1 + \exp(-0.06\ d_{ae})]$$
$$\text{for } 0.05^{*} < d_{ae} \leq 100\ \mu m$$

where: $IPM\ (d_{ae})$ = the collection efficiency
d_{ae} = mass median aerodynamic diameter (MMAD) of particle in µm
*0.05 µm denotes the lowest achievable MMAD cut-point reported for numerous cascade impactors[5]

B. TPM fraction consists of aerosols that are captured according to the following:

$$TPM\ (d_{ae}) = IPM\ (d_{ae})\ [1 - F(x)]$$

where: F(x) = cumulative probability function of the standardized normal variable, x, and TPM represents the collection efficiency.

$$x = \frac{\ln(d_{ae}/\Gamma)}{\ln(\Sigma)}$$

ln = natural logarithm
Γ = 11.64 µm (MMAD)
Σ = 1.5 (geometric standard deviation)

C. RPM fraction consists of particles that are captured according to the following collection efficiency:

$$RPM\ (d_{ae}) = IPM\ (d_{ae})\ [1 - F(x)]$$

where F(x) = same as above, but with Γ = 4.25 µm and Σ = 1.5

The most significant difference from previous definitions is the increase in the median cut-point for a respirable particulate matter sampler from 3.5 µm to 4.0 µm MMAD; this is in accordance with the International Organization for Standardization/ European Standardization Committee (ISO/CEN) protocol.[6,7]

Collection efficiencies representative of several sizes of particles in each of the respective mass fractions are shown in Tables 1, 2, and 3. Documentation for the respective algorithms representative of the 3 mass fractions is found in the literature.[4,7]

TABLE C-1. Inhalable Fraction

Mass Median Aerodynamic Diameter (µm)	Inhalable Particulate Matter Fraction Collected (%)
<0.05	100
1	97
2	94
5	87
10	77
20	65
30	58
40	54.5
50	52.5
100	50

TABLE C-2. Thoracic Fraction

Mass Median Aerodynamic Diameter (µm)	Thoracic Particulate Matter Fraction Collected (%)
<0.05	100
2	94
4	89
6	80.5
8	67
10	50
12	35
14	23
16	15
18	9.5
20	6
25	2

TABLE C-3. Respirable Fraction

Mass Median Aerodynamic Diameter (µm)	Respirable Particulate Matter Fraction Collected (%)
<0.05	100
1	97
2	91
3	74
4	50
5	30
6	17
7	9
8	5
10	1

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APPENDIX D: Commercially Important Tree Species Suspected of Inducing Sensitization

Common	*Latin*
SOFTWOODS	
California redwood	*Sequoia sempervirens*
Eastern white cedar	*Thuja occidentalis*
Pine	*Pinus*
Western red cedar	*Thuja plicata*

Common	*Latin*
HARDWOODS	
Ash	*Fraxinus spp.*
Aspen/Poplar/Cottonwood	*Populus*
Beech	*Fagus*
Oak	*Quercus*
TROPICAL WOODS	
Abirucana	*Pouteria*
African zebra	*Microberlinia*
Antiaris	*Antiaris africana, Antiaris toxicara*
Cabreuva	*Myrocarpus fastigiatus*
Cedar of Lebanon	*Cedra libani*
Central American walnut	*Juglans olanchana*
Cocabolla	*Dalbergia retusa*
African ebony	*Diospryos crassiflora*
Fernam bouc	*Caesalpinia*
Honduras rosewood	*Dalbergia stevensonii*
Iroko or kambala	*Chlorophora excelsa*
Kejaat	*Pterocarpus angolensis*
Kotibe	*Nesorgordonia papaverifera*
Limba	*Terminalia superba*
Mahogany (African)	*Khaya spp.*
Makore	*Tieghemella heckelii*
Mansonia/Beté	*Mansonia altissima*
Nara	*Pterocarpus indicus*
Obeche/African maple/Samba	*Triplochiton scleroxylon*
Okume	*Aucoumea klaineana*
Palisander/Brazilian rosewood/ Tulip wood/Jakaranda	*Dalbergia nigra*
Pau marfim	*Balfourodendron riedelianum*
Ramin	*Gonystylus bancanus*
Soapbark dust	*Quillaja saponaria*
Spindle tree wood	*Euonymus europaeus*
Tanganyike aningre	

APPENDIX E: Threshold Limit Values for Mixtures

Most threshold limit values are developed for a single chemical substance. However, the work environment is often composed of multiple chemical exposures both simultaneously and sequentially. It is recommended that multiple exposures that comprise such work environments be examined to assure that workers do not experience harmful effects.

There are several possible modes of chemical mixture interaction. Additivity occurs when the combined biological effect of the components is equal to the sum of each of the agents given alone. Synergy occurs where the

combined effect is greater than the sum of each agent. Antagonism occurs when the combined effect is less.

The general ACGIH mixture formula applies to the additive model. It is utilized when additional protection is needed to account for this combined effect.

The guidance contained in this Appendix does not apply to substances in mixed phases.

Application of the Additive Mixture Formula

The TLV Basis column found in the table of Adopted Values lists the adverse effect(s) upon which the TLV is based. This column is a resource that may help alert the reader to the additive possibilities in a chemical mixture and the need to reduce the combined TLV of the individual components. Note that the column does not list the deleterious effects of the agent, but rather, lists only the adverse effect(s) upon which the threshold limit was based. The current Documentation of the TLVs and BEIs should be consulted for toxic effects information, which may be of use when assessing mixture exposures.

When two or more hazardous substances have a similar toxicological effect on the same target organ or system, their combined effect, rather than that of either individually, should be given primary consideration. In the absence of information to the contrary, different substances should be considered as additive where the health effect and target organ or system is the same.

That is, if the sum of

$$\frac{C_1}{T_1} + \frac{C_2}{T_2} + \cdots \frac{C_n}{T_n}$$

exceeds unity, the threshold limit of the mixture should be considered as being exceeded (where C_1 indicates the observed atmospheric concentration and T_1 is the corresponding threshold limit; see example). It is essential that the atmosphere is analyzed both qualitatively and quantitatively for each component present in order to evaluate the threshold limit of the mixture.

The additive formula applies to simultaneous exposure for hazardous agents with TWA, STEL, and Ceiling values. The threshold limit value time interval base (TWA, STEL, and Ceiling) should be consistent where possible. When agents with the same toxicological effect do not have a corresponding TLV type, use of mixed threshold limit value types may be warranted. Table E-1 lists possible combinations of threshold limits for the additive mixture formula. Multiple calculations may be necessary.

Where a substance with a STEL or Ceiling limit is mixed with a substance with a TLV–TWA but no STEL, comparison of the short-term limit with the applicable peak exposure may be appropriate. The maximum peak exposure is defined as a value five times the TLV–TWA limit. The amended formula would be:

$$\frac{C_1}{T_{1STEL}} + \frac{C_2}{(T_2)(5)} \leq 1$$

where: T_{1STEL} = the TLV–STEL

T_2 = the TLV–TWA of the agent with no STEL.

TABLE E-1. Possible Combinations of Threshold Limits When Applying the Additive Mixture Formula

Full Shift or Short Term	Agent A	Agent B
Full Shift	TLV–TWA	TLV–TWA
Full Shift	TLV–TWA	TLV–Ceiling
Short Term	TLV–STEL	TLV–STEL
Short Term	TLV–Ceiling	TLV–Ceiling
Short Term	Peak exposure where there is no STEL (5 times TLV–TWA value)	TLV–Ceiling or TLV–STEL
Short Term	TLV–STEL	TLV–Ceiling

The additive model also applies to consecutive exposures of agents that occur during a single workshift. Those substances that have TLV-TWAs (and STELs or peak exposure limits) should generally be handled the same as if they were the same substance, including attention to the recovery periods for STELs and peak exposure limits as indicated in the Introduction to Chemical Substances. The formula does not apply to consecutive exposures of TLV-Ceilings.

Limitations and Special Cases

Exceptions to the above rule may be made when there is a good reason to believe that the chief effects of the different harmful agents are not additive. This can occur when neither the toxicological effect is similar nor the target organ is the same for the components. This can also occur when the mixture interaction causes inhibition of the toxic effect. In such cases, the threshold limit ordinarily is exceeded only when at least one member of the series (C_1/T_1 or C_2/T_2, etc.) itself has a value exceeding unity.

Another exception occurs when mixtures are suspected to have a synergistic effect. The use of the general additive formula may not provide sufficient protection. Such cases at present must be determined individually. Potentiating effects of exposure to such agents by routes other than that of inhalation are also possible. Potentiation is characteristically exhibited at high concentrations, less probably at low. For situations involving synergistic effects, it may be possible to use a modified additive formula that provides additional protection by incorporating a synergy factor. Such treatment of the TLVs should be used with caution, as the quantitative information concerning synergistic effects is sparse.

Care must be considered for mixtures containing carcinogens in categories A1, A2, or A3. Regardless of application of the mixture formula, exposure to mixtures containing carcinogens should be avoided or maintained as low as possible. *See* Appendix A.

The additive formula applies to mixtures with a reasonable number of agents. It is not applicable to complex mixtures with many components (e.g., gasoline, diesel exhaust, thermal decomposition products, fly ash, etc.).

Example

A worker's airborne exposure to solvents was monitored for a full shift as well as one short-term exposure. The results are presented in Table E-2.

TABLE E-2. Example Results

Agent	Full-Shift Results (TLV–TWA)	Short-Term Results (TLV–STEL)
1) Acetone	80 ppm (250 ppm)	325 ppm (500 ppm)
2) Cyclohexanone	2 ppm (20 ppm)	7.5 ppm (50 ppm)
3) Methyl ethyl ketone	90 ppm (200 ppm)	220 ppm (300 ppm)

According to the Documentation of the TLVs and BEIs, all 3 substances indicate irritation effects on the respiratory system and thus would be considered additive. Acetone and methyl ethyl ketone exhibit central nervous system effects.

Full-shift analysis would utilize the formula:

$$\frac{C_1}{T_1} + \frac{C_2}{T_2} + \frac{C_3}{T_3} \leq 1$$

thus,

$$\frac{80}{250} + \frac{2}{20} + \frac{90}{200} = 0.32 + 0.10 + 0.45 = 0.87$$

The full-shift mixture limit is not exceeded.

Short-term analysis would utilize the formula:

$$\frac{C_1}{T_{1STEL}} + \frac{C_2}{T_{2STEL}} + \frac{C_3}{T_{3STEL}} \leq 1$$

thus,

$$\frac{325}{500} + \frac{7.5}{50} + \frac{220}{300} = 0.65 + 0.15 + 0.73 = 1.53$$

The short-term mixture limit is exceeded.

APPENDIX F: Minimal Oxygen Content

Adequate oxygen delivery to the tissues is necessary for sustaining life and depends on (1) the level of oxygen in inspired air, (2) the presence or absence of lung disease, (3) the level of hemoglobin in the blood, (4) the kinetics of oxygen binding to hemoglobin (oxy-hemoglobin dissociation curve), (5) the cardiac output, and (6) local tissue blood flow. For the purpose of the present discussion, only the effects of decreasing the amount of oxygen in inspired air are considered.

The brain and myocardium are the most sensitive tissues to oxygen deficiency. The initial symptoms of oxygen deficiency are increased ventilation, increased cardiac output, and fatigue. Other symptoms that may develop include headache, impaired attention and thought processes, decreased coordination, impaired vision, nausea, unconsciousness, seizures, and death. However, there may be no apparent symptoms prior to unconsciousness. The onset and severity of symptoms depend on many factors such as the magnitude of the oxygen deficiency, duration of exposure, work rate, breathing rate, temperature, health status, age, and pulmonary acclimatization. The initial symptoms of increased breathing and increased heart rate become evident when hemoglobin oxygen saturation is reduced below 90%. At hemoglobin oxygen saturations between 80% and 90%, physiological adjustments occur in healthy adults to resist hypoxia, but in compromised individuals, such as emphysema patients, oxygen therapy would be prescribed for hemoglobin oxygen saturations below 90%. As long as the partial pressure of oxygen (pO_2) in pulmonary capillaries stays above 60 torr, hemoglobin will be more than 90% saturated and normal levels of oxygen transport will be maintained in healthy adults. The alveolar pO_2 level of 60 torr corresponds to 120 torr pO_2 in the ambient air, due to anatomic dead space, carbon dioxide, and water vapor. For additional information on gas exchange and pulmonary physiology see Silverthorn[1] and Guyton.[2]

The US National Institute for Occupational Safety and Health[3] used 60 torr alveolar pO_2 as the physiological limit that establishes an oxygen-deficient atmosphere and has defined an oxygen-deficient atmosphere as one with an ambient pO_2 less than 132 torr.[4] The minimum requirement of 19.5% oxygen at sea level (148 torr pO_2, dry air) provides an adequate amount of oxygen for most work assignments and includes a margin of safety.[5] However, the margin of safety significantly diminishes as the O_2 partial pressure of the atmosphere decreases with increasing altitude, decreases with the passage of low pressure weather events, and decreases with increasing water vapor,[6] such that, at 5,000 feet, the pO_2 of the atmosphere may approach 120 torr because of water vapor and the passage of fronts and at elevations greater than 8,000 feet, the pO_2 of the atmosphere may be expected to be less than 120 torr.

The physiologic effects of oxygen deficiency and oxygen partial pressure variation with altitude for dry air containing 20.948% oxygen are given in Table F-1. No physiological effects due to oxygen deficiency are expected in healthy adults at oxygen partial pressures greater than 132 torr or at elevations less than 5,000 feet. Some loss of dark adaptation is reported to occur at elevations greater than 5,000 feet. At oxygen partial pressures less than 120 torr (equivalent to an elevation of about 7,000 feet or about 5,000 feet accounting for water vapor and the passage of low pressure weather events) symptoms in

unacclimatized workers include increased pulmonary ventilation and cardiac output, incoordination, and impaired attention and thinking. These symptoms are recognized as being incompatible with safe performance of duties.

Accordingly, ACGIH recommends a minimal ambient oxygen partial pressure of 132 torr, which is protective against inert oxygen-displacing gases and oxygen-consuming processes for altitudes up to 5,000 feet. Figure F-1 is a plot of pO_2 with increasing altitude, showing the recommended minimal value of 132 torr. If the partial pressure of oxygen is less than 132 torr or if it is less than the expected value for that altitude, given in Table F-1, then additional work practices are recommended such as thorough evaluation of the confined space to identify the cause of the low oxygen concentration; use of continuous

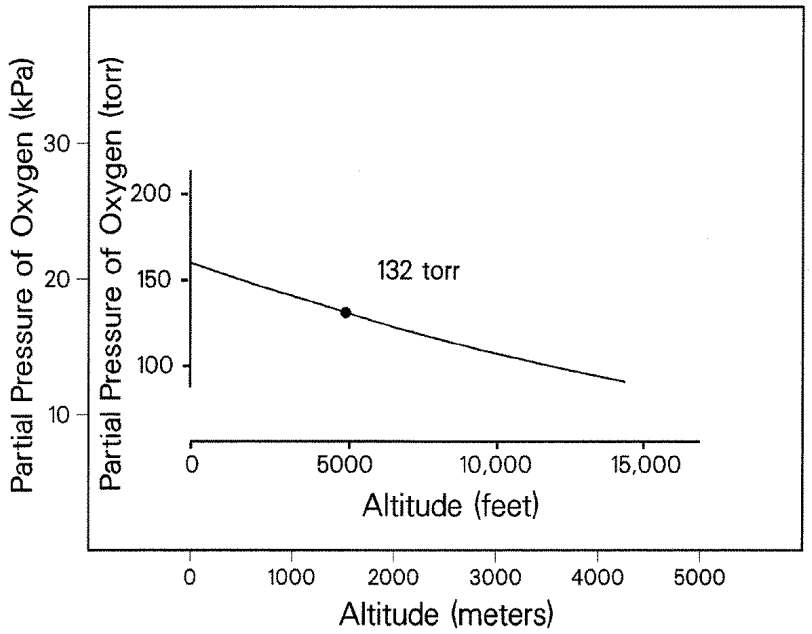

FIGURE F-1. Plot of oxygen partial pressure (pO_2) (expressed in torr and kPa) with increasing altitude (expressed in feet and meters), showing the recommended oxygen partial pressure of 132 torr.

monitors integrated with warning devices; acclimating workers to the altitude of the work, as adaptation to altitude can increase an individual's work capacity by 70%; use of rest-work cycles with reduced work rates and increased rest periods; training, observation, and monitoring of workers; and easy, rapid access to oxygen-supplying respirators that are properly maintained.

Oxygen-displacing gases may have flammable properties or may produce physiological effects, so that their identity and source should be thoroughly investigated. Some gases and vapors, when present in high concentrations in air, act primarily as simple asphyxiants without other significant physiologic effects. A TLV may not be recommended for each simple asphyxiant because the limiting factor is the available oxygen. Atmospheres deficient in O_2 do not provide adequate warning and most simple asphyxiants are odorless. Account should be taken of this factor in limiting the concentration of the asphyxiant particularly at elevations greater than 5,000 feet where the pO_2 of the atmosphere may be less than 120 torr.

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3. US National Institute for Occupational Safety and Health (NIOSH). A guide to industrial respiratory protection. DHEW (NIOSH) Pub No 76-198. 1976; Cincinnati (OH): NIOSH.

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TABLE F-1. Barometric Pressure, Oxygen Partial Pressure, and Percent Oxygen Concentration Variation with Altitude and Physiological Effect (adapted from McManus[5])

Altitude, Feet (meters)	Barometric Pressure, torr; Dry Air[a] (kilopascals)	pO_2 Equivalent, torr; Dry Air at 20.948% O_2[b] (kilopascals)	% O_2 Equivalent, Dry Air at Sea Level[c] (%)	Physiologic Effect of pO_2 Levels[d]
0 (0)	760 (101)	159 (21.2)	20.9	
1,000 (305)	731 (97.4)	153 (20.4)	20.1	
2,000 (610)	704 (93.8)	147 (19.6)	19.3	
3,000 (914)	677 (90.3)	142 (18.9)	18.7	
4,000 (1,219)	652 (86.9)	137 (18.3)	18.0	
5,000 (1,524)	627 (83.6)	131 (17.5)	17.2	None in healthy adults
6,000 (1,829)	603 (80.4)	126 (16.8)	16.6	Loss of dark adaptation can occur at elevations above 5,000 feet
7,000 (2,134)	580 (77.3)	121 (16.1)	16.0	Increased pulmonary ventilation and cardiac output, incoordination, and impaired attention and thinking
8,000 (2,438)	559 (74.5)	117 (15.6)	15.4	Rapid exposure to altitudes over 8,000 feet may cause high altitude sickness (respiratory alkalosis, headache, nausea, and vomiting) in unacclimatized individuals. Rapid ascent increases the risk of high altitude pulmonary edema and cerebral edema
9,000 (2,743)	537 (71.6)	112 (14.9)	14.7	

TABLE F-1 (cont.). Barometric Pressure, Oxygen Partial Pressure, and Percent Oxygen Concentration Variation with Altitude and Physiological Effect adapted from McManus[5])

Altitude, Feet (meters)	Barometric Pressure, torr; Dry Air[a] (kilopascals)	pO_2 Equivalent, torr; Dry Air at 20.948% O_2[b] (kilopascals)	% O_2 Equivalent, Dry Air at Sea Level[c] (%)	Physiologic Effect of pO_2 Levels[d]
10,000 (3,048)	517 (68.9)	108 (14.4)	14.2	
11,000 (3,353)	498 (66.4)	104 (13.9)	13.7	Abnormal fatigue on exertion, faulty coordination, impaired judgment, emotional upset
12,000 (3,658)	479 (63.8)	100 (13.3)	13.2	
13,000 (3,962)	461 (61.5)	98 (12.9)	12.8	
14,000 (4267)	443 (59.1)	93 (12.4)	12.2	Impaired respiration, very poor judgment and coordination, tunnel vision

[a] Calculated from $P_{re:\ sea\ level} = 760 \times e^{-(\text{altitude in feet}/25970)}$

[b] Calculated from $pO_2 = 0.20948 \times 760 \times e^{-(\text{altitude in feet}/25970)}$

[c] Calculated from: $P_{\%O2,} = 20.948 \times e^{-(\text{altitude in feet}/25970)}$

[d] The approximate physiologic effect in healthy adults is influenced by duration of the oxygen deficiency, work rate, breathing rate, temperature, health status, age, and pulmonary acclimatization.

APPENDIX G: Substances Whose Adopted Documentation and TLVs Were Withdrawn for a Variety of Reasons, Including Insufficient Data, Regrouping, etc. (Individual entries will remain for a 10-year period, commencing with the year of withdrawal)

Substance [CAS]	Year Withdrawn	Reason
Acetylene [74-86-2]	2015	See Appendix F: Minimal Oxygen Content
Aliphatic hydrocarbon gases, Alkanes [C1–C4]	2013	Methane, ethane, propane, liquefied petroleum gas (LPG) and natural gas — see Appendix F: Minimal Oxygen Content. Butane and isobutane — see Butane, all isomers
Argon [7440-37-1]	2014	See Appendix F: Minimal Oxygen Content
n-Butyl acetate [123-86-4]	2016	See Butyl acetates, all isomers
sec-Butyl acetate [105-46-4]	2016	See Butyl acetates, all isomers
tert-Butyl acetate [540-88-5]	2016	See Butyl acetates, all isomers
Calcium chromate [13765-19-0], as Cr	2018	See Chromium and inorganic compounds
Calcium silicate, synthetic nonfi brous [1344-95-2]	2016	Insufficient data
Chromite ore processing (Chromate), as Cr	2018	See Chromium and inorganic compounds

APPENDIX G (cont.): Substances Whose Adopted Documentation and TLVs Were Withdrawn for a Variety of Reasons, Including Insufficient Data, Regrouping, etc. (Individual entries will remain for a 10-year period, commencing with the year of withdrawal)

Substance [CAS]	Year Withdrawn	Reason
Chromyl chloride [14977-61-8]	2018	See Chromium and inorganic compounds
Cyclopentadiene [542-92-7]	2019	See Dicyclopentadiene, including cyclopentadiene
Ethyl cyanoacrylate [7085-85-0]	2018	See Cyanoacrylates, ethyl and methyl
Glycerin mist [56-81-5]	2013	Insufficient data relevant to human occupational exposure
Helium [7440-59-7]	2014	See Appendix F: Minimal Oxygen Content
Hydrogen [1333-74-0]	2014	See Appendix F: Minimal Oxygen Content
Isobutyl acetate [110-19-0]	2016	See Butyl acetates, all isomers
Isopropyl acetate [108-21-4]	2018	See Propyl acetate isomers
Methyl 2-cyanoacrylate [137-05-3]	2018	See Cyanoacrylates, ethyl and methyl
Neon [7440-01-9]	2014	See Appendix F: Minimal Oxygen Content

APPENDIX G (cont.): Substances Whose Adopted Documentation and TLVs Were Withdrawn for a Variety of Reasons, Including Insufficient Data, Regrouping, etc. (Individual entries will remain for a 10-year period, commencing with the year of withdrawal)

Substance [CAS]	Year Withdrawn	Reason
Nitrogen [7727-37-9]	2014	See Appendix F: Minimal Oxygen Content
Nonane [111-84-2], all isomers	2012	See Nonane
Piperazine dihydrochloride [142-64-3]	2012	See Piperazine and salts
n-Propyl acetate [109-60-4]	2018	See Propyl acetate isomers
Rosin core solder decomposition products (colophony) [8050-09-7]	2021	See Resin acids
Strontium chromate [7789-06-2], as Cr	2018	See Chromium and inorganic compounds
Zinc chromates [11103-86-9; 13530-65-9; 37300-23-5], as Cr	2018	See Chromium and inorganic compounds

APPENDIX H: Reciprocal Calculation Method for Certain Refined Hydrocarbon Solvent Vapor Mixtures

The reciprocal calculation procedure (RCP) is a method for deriving occupational exposure limits (OELs) for certain refined hydrocarbon solvents based on their bulk composition. Refined hydrocarbon solvents often are found as mixtures created by distillation of petroleum oil over a particular boiling range. These mixtures may consist of up to 200 components consisting of aliphatic (alkane), cycloaliphatic (cycloalkane) and aromatic hydrocarbons ranging from 5 to 15 carbons.

The goal of the TLV-CS Committee is to recommend TLVs for all substances where there is evidence of health effects at airborne concentrations encountered in the workplace. When a sufficient body of evidence exists for a particular substance or mixture, a TLV is established. However, hydrocarbon solvents are often complex and variable in composition. The use of the mixture formula, found in Appendix E: Threshold Limit Values for Mixtures, is difficult to apply in such cases because these petroleum mixtures contain a large number of unique compounds, many of which do not have a TLV recommendation. The RCP does not replace TLVs but rather calculates a guidance OEL (e.g., $GGV_{mixture}$) based on the composition of a specific complex mixture.

There are two aspects of the RCP — the methodology and the group guidance values (GGVs). The methodology is based on the special case formula found in pre-2004 versions of the Mixture Appendix in *TLVs and BEIs Based on the Documentation of the Threshold Limit Values for Chemical Substances and Physical Agents and Biological Exposure Indices*. The RCP formula calculates a unique OEL based on the mass composition of the mixture, the GGVs and where applicable, substance-specific TLVs.

Group guidance values are categorized based on similar chemical and toxicological concerns. Several entities (both trade groups and regulatory authorities) have adopted group guidance values to utilize with the reciprocal mixture formula (RMF).[1-3] Two examples of published GGVs are found in Table 1. A mixture-specific time-weighted-average limit ($GGV\text{-}TWA_{mixture}$) is calculated based on the mass percent makeup of the designated groups utilizing the reciprocal mixture formula and the GGVs from column *B* or *C* and TLV values for the substances in column *D* found in Table 1.

ACGIH considers this method to be applicable for mixtures if the toxic effects of individual constituents are additive (i.e., similar toxicological effect on the same target organ or system). The principal toxicological effects of hydrocarbon solvent constituents are acute central nervous system (CNS) depression (characterised by effects ranging from dizziness and drowsiness to anesthesia), eye, and respiratory tract irritation.[3,4]

Application

The RCP is a special use application. It applies only to hydrocarbon solvents containing saturated aliphatics (normal, iso-alkanes and cycloalkanes) and aromatics with a carbon number of C_5 to C_{15} derived from petroleum and

boiled in the range of 35°C to 329°C. It does not apply to petroleum-derived fuels, lubricating oils, or solvent mixtures for which there exists a unique TLV. GGVs are not appropriate for compounds that do not have either CNS impairment or irritation effects.

Where the mixture is comprised entirely of compounds with unique TLVs, the mixture should be handled according to Appendix E. When the mixture contains an appreciable amount of a component for which there is a TLV and when the use of the TLV results in a lower $GGV_{mixture}$, those specific values should be entered into the RCP (*see* column *D*, Table 1). When the mixture itself has been assigned a unique TLV, that value should be utilized rather than the procedures found in this appendix.

Peak exposures above the calculated GGV-$TWA_{mixture}$ should be handled according to the procedures found in the Introduction to the TLVs (*see Peak Exposures*).

The reciprocal calculation mixture formula is:

$$GGV_{mixture} = \frac{1}{\frac{F_a}{GGV_a} + \ldots + \frac{F_n}{GGV_n}}$$

where:

$GGV_{mixture}$ = the calculated 8-hour TWA–OEL for the mixture

GGV_a = the guidance value (or TLV) for group (or component) *a*

F_a = the liquid mass fraction of group (or component) *a* in the hydrocarbon mixture (value between 0 and 1)

GGV_n = the guidance value (or TLV) for the n^{th} group (or component)

F_n = the liquid mass fraction of the n^{th} group (or component) in the hydrocarbon mixture (value between 0 and 1)

The resulting $GGV_{mixture}$ should identify the source of GGVs used in the calculation (i.e., column *B* or *C*).

The resulting calculated $GGV_{mixture}$ value should follow established recommendations regarding rounding. For calculated values <100 mg/m^3, round to the nearest 25. For calculated values between 100 and 600 mg/m^3, round to the nearest 50, and for calculated values >600 mg/m^3, round to the nearest 200 mg/m^3.

TABLE H-1. Group Guidance Values

A Hydrocarbon Group	B McKee et al.,[3] (mg/m^3)	C UK-HSE[2] (mg/m^3)	D ACGIH Unique TLVs and Compounds with *different or additional critical effects (italics)*[a]
C5-C6 Alkanes	1,500	1,800	Pentane, all isomers Hexane isomers *n-Hexane peripheral neuropathy*[a]
C7-C8 Alkanes	1,500	1,200	Heptane, all isomers Octane, all isomers
C5-C6 Cycloalkanes	1,500	1,800	Cyclopentane Cyclohexane
C7-C8 Aromatics	200	500	Xylene, all isomers Ethyl benzene *Toluene visual impairment, reproductive*[a]
C9-C15 Alkanes	1,200	1,200	n-Nonane
C9-C15 Cycloalkanes	1,200	800	
C9-C15 Aromatics	100	500	Trimethyl benzene, isomers Cumene *Naphthalene hematologic effects*[a] *Methylnaphthalene lung damage** *Indene liver damage*[a]

[a] See limitation #2. These compounds have critical effects (TLV basis) beyond those utilized for the RCP mixture. They are also typically significantly below the recommended GGV for their hydrocarbon group. Whenever present in the mixture in appreciable amounts, these components need to be identified and monitored individually to ensure that the individual TLV is not exceeded.

Limitations

1. The reciprocal formula requires that the composition of the mixture be characterized at least to the detail of mass percent of the groups/compounds found in Table 1.
2. Additional care should be utilized for solvent components that have unique toxicological properties and have individual TLVs significantly less than the GGV to which they would belong. These are marked with an asterisk in Table 1 (e.g., n-hexane). Whenever present in the mixture, these components should be identified and sampled individually to assure exposures are below the TLV.
3. Care in the use of GGV/RMF should be observed where the mixture in question is known to have significant toxicokinetic interactions of components that are manifested at or below GGV levels.
4. The use of the reciprocal formula should be restricted to applications where the boiling points of the solvents in the mixture are relatively narrow, within a range of less than 45°C (i.e., vapor pressure within approximately one order of magnitude). The procedure should not be used in situations where the liquid composition is significantly different from the vapor composition. If these conditions cannot be met, the reciprocal formula can be utilized by substituting $F_{(n)}$ in the equation with the vapor mass fraction for each group (*n*) in the hydrocarbon mixture, based on situation-specific airborne concentration measurements.
5. The group guidance values apply only to vapors and do not apply to mists or aerosols. The GGV/RMF procedure does not apply to mixtures containing olefins or other unsaturated compounds or carcinogenic polycyclic aromatic hydrocarbons (PAHs).
6. The GGV/RCP procedure does not apply to benzene. Benzene is not typically found in the liquid phase of refined hydrocarbon solvents above 0.01% v/v but in any case should be monitored separately to assure that airborne concentrations are not being exceeded.[3,5]

Example

A solvent containing the following mass composition is matched with the appropriate group guidance value:

Component	Percent by weight	Group Guidance Value (mg/m^3)
C7-C8 alkanes cycloalkanes	45%	1,500
C9-C10 alkanes cycloalkanes	40%	1,200
C7-C8 aromatics	9%	200
Toluene	6%	75

Based on Column B, Table 1 (McKee et al.[3]), the $GGV_{mixture}$ would be:

$$GGV_{mixture} = \frac{1}{\frac{.45}{1500} + \frac{.40}{1200} + \frac{.09}{200} + \frac{.06}{75}} = \frac{1}{.001884}$$

= 531 (rounded to 550 mg/m^3)

Toluene (part of the aromatic C7, 8 fraction) is added as a TLV rather than a GGV since it makes a difference in the resulting $GGV_{mixture}$.

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2024
Biological Exposure Indices

Adopted by ACGIH with Intended Changes

Contents

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INTRODUCTION TO THE BIOLOGICAL EXPOSURE INDICES

Biological monitoring provides an important means to assess exposure and health risk to workers. It entails measurement of a chemical determinant in the biological media of those exposed and is an indicator of the uptake of a substance. Biological Exposure Indices (BEIs) are guidance values for evaluating biological monitoring results. BEIs generally represent the levels of determinants that are most likely to be observed in specimens collected from healthy workers who have been exposed to chemicals to the same extent as workers with inhalation exposure at the Threshold Limit Value–Time-Weighted Average (TLV–TWA). However, there are BEIs for chemicals for which the TLVs are based on protection against nonsystemic effects (e.g., irritation or respiratory impairment) where biological monitoring is desirable because of the potential for significant absorption via an additional route of entry (usually the skin). There are also BEIs that better predict health effects than air levels and finally, BEIs that are based on the levels in the environmentally exposed population. The BEI generally indicates a concentration below which nearly all workers should not experience adverse health effects. The BEI determinant can be the chemical itself; one or more metabolites; or a characteristic, reversible biochemical change induced by the chemical. The specimens used for BEIs are urine, blood, or exhaled air. The BEIs are not intended for use as a measure of adverse effects or for diagnosis of occupational illness.

Biological monitoring can assist the occupational health professional (occupational and industrial hygienists, occupational physicians and nurses, etc.) to determine absorption via the skin or gastrointestinal system, in addition to that by inhalation; assess body burden; reconstruct past exposure; detect nonoccupational exposures among workers; test the efficacy of personal protective equipment and engineering controls; and monitor work practices.

Biological monitoring serves as a complement to exposure assessment by air sampling and medical surveillance. The existence of a BEI does not indicate a need to conduct biological monitoring. Conducting, designing, and interpreting biological monitoring protocols and the application of the BEI require professional experience in occupational health and reference to the current edition of the Documentation of the TLVs and BEIs.

Editor's note: The approximate year that the current Documentation was last substantially reviewed and, where necessary, updated may be found following the CAS number for each of the adopted entries in the alphabetical listing, e.g., Acetone [67-64-1] (2014). The reader is advised to refer to the "BEI Chronology" section in each Documentation for a brief history of the BEI recommendations and notations.

Documentation

It is essential that the user consult the specific BEI Documentation before designing biological monitoring protocols and interpreting BEIs for a specific agent. The Documentation for each compound contains the explicit information that is only discussed in general in this Introduction. In addition, each BEI Documentation provides a chronology that traces all BEI recommended actions for the chemical substance in question.

BEIs are developed by Committee consensus through an analysis and evaluation process. The detailed scientific criteria and justification for each BEI can be found in the Documentation of the TLVs and BEIs. The principal material evaluated by the BEI Committee includes peer-reviewed published data taken from the workplace (e.g., field studies), data from controlled exposure studies, and from appropriate toxicokinetic modeling when available. The results of animal research are also considered when relevant. The Documentation provides essential background information and the scientific reasoning used in establishing each BEI. Information given includes the analytical methods, possible potential for confounding exposures, specimen collection recommendations, limitations, as well as other essential information, specific for each compound and analyte.

In recommending a BEI, ACGIH considers whether published data are of reasonable quality and may also consider unpublished data if a complete copy of the data/report is provided to ACGIH. However, unpublished data are never used as the primary basis for a BEI, although it may provide a secondary support. There are numerous instances when analytical techniques are available for the measurement of a biological determinant, but published information is unavailable or inadequate to determine a BEI. The data needed to establish a BEI include comprehensive assessment of total exposure and/or health effects. Therefore, occupational health professionals are encouraged to accumulate and report biological monitoring data together with exposure and health data.

Relationship of BEIs to TLVs

BEI determinants are an index of an individual's uptake of a chemical by all routes. In some cases they correspond to the TLV as a "safe" level without reported health effects. In other cases they may reflect the highest 5% of levels seen in the general population. In addition, some BEIs are without a numerical value and/or provide only qualitative estimates of exposure. These indices are useful to confirm that an exposure to a specific agent is occurring. The basis of each BEI is provided in the Documentation. Air monitoring to determine the TLV indicates the potential inhalation exposure of an individual or group. The internal dose for individuals within a workgroup may be different for a variety of reasons, some of which are indicated below:

- Exposure by routes other than inhalation, usually dermal, is often a major reason why there is less than perfect concordance between air sampling and biological monitoring. This is often the strongest argument for doing biological monitoring.
- Physiological makeup and health status of the worker, such as body build, diet (water and fat intake), metabolism, body fluid composition, age, gender, pregnancy, medication, and disease state.
- Occupational exposure factors, such as the work-rate intensity and duration, temperature and humidity, coexposure to other chemicals, and other work factors.
- Nonoccupational exposure factors, such as community and home air pollution, water and food components, personal hygiene, smoking, alcohol and drug intake, exposure to household products, or exposure to chemicals from hobbies or from another workplace.

- Methodological factors, which include specimen contamination or deterioration during collection and storage and bias of the selected analytical method.
- Location of the air monitoring device in relation to the worker's breathing zone.
- Particle size distribution and bioavailability.
- Variable effectiveness of personal protective devices.

It is important that the reader consult the Documentation of the TLVs and BEIs to understand the importance of each of these factors for each agent.

Specimen Collection

Because the concentration of some determinants can change rapidly, the specimen collection time (sampling time) is very important and must be observed and recorded carefully. The sampling time is specified in the BEI and is determined by the duration of retention of the determinant, modified in some cases by practicality (for example, if the peak level is expected several hours after the end of a shift). Substances and determinants that accumulate may not require a specific sampling time. An explanation of the BEI sampling time is as follows:

Sampling Time	Recommended Collection
1. Prior to shift	16 hours after exposure ceases, but before any exposure on sampling day
2. Prior to last shift	Prior to last shift of a workweek
3. Increase during shift	Requires pre- and post-shift sample collection
4. During shift	Anytime after 2 hours of exposure
5. End of shift	As soon as possible after exposure ceases
6. End of the workweek	After 4 or 5 consecutive working days with exposure
7. Discretionary/not critical	At any time[a]

[a] These determinants have long half-lives and their levels may take weeks, months or years after a worker first begins their job to approach steady state and be comparable to the BEI. Health professionals should note that if sequential samples taken early in a worker's exposure career show a marked increase, an overexposure situation might be developing and must be addressed despite the values being below the BEI.

Urine Specimen Acceptability

Urine specimens that are highly dilute or highly concentrated are generally not suitable for biomonitoring. The World Health Organization has adopted guidelines (without reference) for acceptable limits on urine specimens as follows:

Creatinine concentration: >0.3 g/L and <3.0 g/L
or
Specific gravity: >1.010 and <1.030

Specimens falling outside either of these ranges should be discarded and another specimen should be collected when possible.

Some BEIs for determinants whose concentration is dependent on urine output are expressed relative to creatinine concentration. For other determinants such as those excreted by diffusion into the renal tubules, correction for urine output is not appropriate. In general, the best correction method is chemical-specific, but research data sufficient to identify the best method may not be available. When the field data are only available as adjusted for creatinine, the BEI will continue to be expressed relative to creatinine; in other circumstances, no correction is recommended, and the BEI will be expressed as concentration in urine (e.g., µg/L).

Notation

B = Background

The determinant may be present in biological specimens collected from subjects who have not been occupationally exposed, at a concentration that could affect interpretation of the result. A **B** notation is assigned to a determinant when the observed 95th percentile value of a random sample, from national population studies, such as the NHANES surveys, is more than 20% of the BEI. When general population data are not available to make this assessment, the BEI Committee may assign a **B** notation based on its interpretation of the available data in the scientific literature. In this case, the rationale for the notation is provided in the Documentation for the particular Index. Such background concentrations are incorporated in the BEI value.

Nq = Nonquantitative

Biological monitoring should be considered for this compound based on the review; however, a specific BEI could not be determined due to insufficient data.

Ns = Nonspecific

The determinant is nonspecific, since it is also observed after exposure to other chemicals.

Sq = Semiquantitative

The biological determinant is an indicator of exposure to the chemical, but the quantitative interpretation of the measurement is ambiguous. These determinants should be used as a screening test if a quantitative test is not practical or as a confirmatory test if the quantitative test is not specific and the origin of the determinant is in question.

Pop = Population based

Pop indices are assigned when there are insufficient data to establish a numerical BEI but where there are sufficient data on background levels in the general population. **Pop** values can be based on the 95th percentile of large studies of the general population, like the NHANES surveys by the CDC, or they can be based on nonoccupationally exposed populations from the scientific literature.

Pop values are not health-based and are intended to give the health professional guidance regarding exposures that are likely to be occupational and not from the general environment. A measurement at or above a **Pop** level will have a high probability of resulting from an occupational exposure.

Quality Assurance

Each aspect of biological monitoring should be conducted within an effective quality assurance (QA) program. The appropriate specimen must be collected at the proper time, without contamination or loss, utilizing a suitable container. Donor identification, time of exposure, source of exposure, and the sampling time must be recorded. The analytical method used by the laboratory must have the accuracy, sensitivity, and specificity needed to produce results consistent with the BEI. Appropriate quality control specimens should be included in the analysis, and the laboratory must follow routine quality control rules. Whenever possible, the laboratory should participate in an external proficiency program.

The occupational health professional may also provide known challenge samples to the laboratory along with worker specimens (e.g., blanks, purchased specimens containing the determinant, or split specimens). These challenges will enable the occupational health professional to assess the ability to process, analyze, and report results properly, and to have confidence in their ability to estimate exposure.

The most effective means for controlling laboratory quality is through an external QA/QC program.

Application of BEIs

BEIs are intended as guidelines to be used in the evaluation of potential health hazards in the practice of occupational hygiene. BEIs do not indicate a sharp distinction between hazardous and nonhazardous exposures. For example, it is possible for an individual's determinant concentration to exceed the BEI without incurring an increased health risk. If measurements in specimens obtained from a worker on different occasions exceed the BEI, the cause of the excessive value should be investigated and action taken to reduce the exposure. An investigation is also warranted if measurements in specimens obtained from a group of workers at the same workplace and workshift exceed the BEI. It is desirable that relevant information on related operations in the workplace be recorded.

Due to the variable nature of concentrations in biological specimens, administrative action should not be normally based on a single result, but on measurements of multiple samplings, or an analysis of a repeat specimen. However, it may be appropriate to remove the worker from exposure following

a single high result if there is reason to believe that significant exposure may have occurred.

BEIs apply to 8-hour exposures, 5 days per week. Although modified work schedules are sometimes used in various occupations, the BEI Committee does not recommend that any adjustment or correction factor be applied to the BEIs (i.e., the BEIs should be used as listed, regardless of the work schedule).

Use of the BEI should be applied by a knowledgeable occupational health professional. Toxicokinetic and toxicodynamic information is taken into account when establishing the BEI; thus, some knowledge of the metabolism, distribution, accumulation, excretion, and effect(s) is helpful in using the BEI effectively. ACGIH may be contacted for technical assistance on any BEI issue. The BEI is a guideline for the control of potential health hazards to the worker and should not be used for other purposes. The values are inappropriate to use for the general population or for nonoccupational exposures. The BEI values are neither rigid lines between safe and dangerous concentrations nor are they an index of toxicity.

Note: It is essential to consult the BEI Documentation before designing biological monitoring protocols and interpreting BEIs. In addition, each BEI Documentation provides a chronology that traces all BEI actions for the chemical substance in question.

ADOPTED BIOLOGICAL EXPOSURE DETERMINANTS

Chemical [CAS No.] (Documentation date) *Determinant*	*Sampling Time*	*BEI*	*Notation*
Acetone [67-64-1] (2014)			
Acetone in urine	End of shift	25 mg/L	Ns
Acrylamide [79-06-1] (2022)			
N-(2-Carbamoylethyl)valine (CbEV) in blood	Not critical	500 pmol/g globin* * After 120 days of representative work/exposure to acrylamide	B
S-(2-Carbamoylethyl)mercapturic acid (AAMA) in urine	End of shift	800 µg/g creatinine	B
Aniline [62-53-3] (2020)			
Aniline in urine ★	End of shift	0.5 mg/L	—
Arsenic (and soluble inorganic compounds) [7440-38-2] (2023) * Excludes gallium arsenide and arsine	End of shift End of workweek	15 µg/g creatinine	Pop
Inorganic arsenic plus methylated metabolites in urine			
Benzene [71-43-2] (1999)			
S-Phenylmercapturic acid in urine	End of shift	25 µg/g creatinine	B
t,t-Muconic acid in urine	End of shift	500 µg/g creatinine	B
1,3-Butadiene [106-99-0] (2005)			
1,2 Dihydroxy-4-(N-acetylcysteinyl)-butane in urine	End of shift	2.5 mg/L	B, Sq
Mixture of N-1- and N-2-(hydroxybutenyl)valine hemoglobin (Hb) adducts in blood	Not critical	2.5 pmol/g Hb	Sq

ADOPTED BIOLOGICAL EXPOSURE DETERMINANTS

Chemical [CAS No.] (Documentation date) *Determinant*	*Sampling Time*	*BEI*	*Notation*
2-Butoxyethanol [111-76-2] (2006)			
Butoxyacetic acid (BAA) in urine★	End of shift	200 mg/g creatinine	—
Cadmium [7440-43-9] and inorganic compounds (2015)			
Cadmium in urine	Not critical	5 μg/g creatinine	B
Cadmium in blood	Not critical	5 μg/L	B
Carbon disulfide [75-15-0] (2008)			
2-Thioxothiazolidine-4-carboxylic acid (TTCA) in urine	End of shift	0.5 mg/g creatinine	B, Ns
Carbon monoxide [630-08-0] (2015)			
Carboxyhemoglobin in blood	End of shift	3.5% of hemoglobin	B, Ns
Carbon monoxide in end-exhaled air	End of shift	20 ppm	B, Ns
Chlorobenzene [108-90-7] (2006)			
4-Chlorocatechol in urine★	End of shift at end of workweek	100 mg/g creatinine	Ns
p-Chlorophenol in urine★	End of shift at end of workweek	20 mg/g creatinine	Ns

ADOPTED BIOLOGICAL EXPOSURE DETERMINANTS

Chemical [CAS No.] (Documentation date) / *Determinant*	*Sampling Time*	*BEI*	*Notation*
Cholinesterase-inhibiting pesticides (2017)			
Acetylcholinesterase activity in red blood cells	End of shift	70% of individual's baseline activity**	Ns
and			
Butyrylcholinesterase activity in serum or plasma	End of shift	60% of individual's baseline activity**	Ns
** The average of 2 baseline respective cholinesterase activity determinations 3 days apart, with no exposures to enzyme inhibiting pesticides for at least 30 days, is recommended for each worker prior to exposure to cholinesterase inhibitors because of large inter-individual differences in published baseline values. To be established at least once a year. Removal from workplace exposures is recommended until the cholinesterase activity returns to within 20% of baseline.			
Chromium [7440-47-3] (2020)			
Total chromium in urine	End of shift at end of workweek	0.7 μg/L	Pop
Cobalt [7440-48-4] and inorganic compounds, including Cobalt oxides but not combined with Tungsten carbide (2014)			
Cobalt in urine	End of shift at end of workweek	15 μg/L	Ns
Cobalt with Tungsten carbide			
Cobalt in urine	End of shift at end of workweek	—	Ns, Nq
Cyclohexane [110-82-7] (2021)			
1,2-Cyclohexanediol in urine	End of shift, end of workweek	50 mg/g creatinine	Ns
Cyclohexanol [108-93-0] (2003)			
1,2-Cyclohexanediol in urine ★	End of shift at end of workweek	—	Nq, Ns
Cyclohexanol in urine ★	End of shift	—	Nq, Ns

ADOPTED BIOLOGICAL EXPOSURE DETERMINANTS

Chemical [CAS No.] (Documentation date) *Determinant*	*Sampling Time*	*BEI*	*Notation*
Cyclohexanone [108-94-1] (2003)			
1,2-Cyclohexanediol in urine★	End of shift at end of workweek	80 mg/L	Ns, Sq
Cyclohexanol in urine★	End of shift	8 mg/L	Ns, Sq
Dichloromethane [75-09-2] (2004)			
Dichloromethane in urine	End of shift	0.3 mg/L	Sq
* Di(2-ethylhexyl)phthalate (DEHP) [117-81-7] (2023)			
Mono(2-ethylhexyl)phthalate in urine★	End of shift	5 µg/g creatinine	Pop
Mono(2-ethyl-5-hydroxyhexyl)phthalate in urine★	End of shift	20 µg/g creatinine	Pop
Mono(2-ethyl-5-oxohexyl)phthalate in urine★	End of shift	15 µg/g creatinine	Pop
Mono(2-ethyl-5-carboxypentyl)phthalate in urine★	End of shift	25 µg/g creatinine	Pop
Mono(2-carboxymethyl-hexyl)phthalate in urine★	End of shift	Not available	—
Dimethylacetamide [127-19-5] (2022)			
N-Methylacetamide in urine	End of shift at end of workweek	30 mg/g creatinine	—
Dimethylformamide [68-12-2] (2016)			
Total N-Methylformamide in urine**	End of shift	30 mg/L	—
N-Acetyl-S-(N-methylcarbamoyl) cysteine in urine	End of shift at end of workweek	30 mg/L	—
** Total N-Methylformamide represents the sum of N-Methylformamide and N-(Hydroxymethyl)-N-Methylformamide			

ADOPTED BIOLOGICAL EXPOSURE DETERMINANTS

Chemical [CAS No.] (Documentation date) *Determinant*	*Sampling Time*	*BEI*	*Notation*
2-Ethoxyethanol (EGEE) [110-80-5] and 2-Ethoxyethyl acetate (EGEEA) [111-15-9] (2022)			
2-Ethoxyacetic acid in urine	End of shift at end of workweek	40 mg/g creatinine	—
* Ethyl benzene [100-41-4] (2023)	End of shift	150 mg/g creatinine	
Sum of mandelic acid and phenylglyoxylic acid in urine			Ns
Ethylene oxide [75-21-8] (2018)			
N-(2-hydroxyethyl)valine (HEV) hemoglobin adducts	Not critical	5,000 pmol HEV/g globin**	Ns
S-(2-hydroxyethyl)mercapturic acid (HEMA) in urine	End of shift	5 μg HEMA/g creatinine	Pop, Ns
** Applies to workers having representative Ethylene oxide exposure during the previous 120 days.			
N-Ethyl-2-pyrrolidone [2687-91-4] (2018)			
5-Hydroxy-N-ethyl-2-pyrrolidone (5-HNEP) in urine★★	End of shift	—	Nq
Fluorides (2011)			
Fluoride in urine	Prior to shift	2 mg/L	B, Ns
Fluoride in urine	End of shift	3 mg/L	B, Ns
Furfural [98-01-1] (2022)			
Furoic acid in urine★	End of shift	200 mg/L	Ns
Hexamethylene diisocyanate [822-06-0] (2014)			
1,6-Hexamethylene diamine in urine★	End of shift	15 μg/g creatinine	Ns

ADOPTED BIOLOGICAL EXPOSURE DETERMINANTS

Chemical [CAS No.] (Documentation date) *Determinant*	*Sampling Time*	*BEI*	*Notation*
n-Hexane [110-54-3] (2018)			
2,5-Hexanedione in urine★★	End of shift	0.5 mg/L	—
Indium [7440-74-6] and Indium inorganic compounds, including Indium tin oxide and Indium oxide (2021)			
Indium (In) in serum or plasma	Not critical	1 μg/L	—
Lead and Inorganic compounds [7439-92-1] (2016)			
Lead in blood	Not critical	200 μg/L	—
Note: Persons applying this BEI are encouraged to counsel female workers of child-bearing age about the risk of delivering a child with a PbB over the current CDC reference value. (CDC: Guidelines for the identification and management of lead exposure in pregnant and lactating women, 2010.)			
Mercury, elemental [7439-97-6] (2012)			
Mercury in urine	Prior to shift	20 μg/g creatinine	—
Methanol [67-56-1] (2004)			
Methanol in urine	End of shift	15 mg/L	B, Ns
Methemoglobin inducers (2020)			
Methemoglobin in blood	During or end of shift	5% of hemoglobin	B, Ns
2-Methoxyethanol [109-86-4] and 2-Methoxyethyl acetate [110-49-6] (2009)			
2-Methoxyacetic acid in urine	End of shift at end of workweek	1 mg/g creatinine	—

ADOPTED BIOLOGICAL EXPOSURE DETERMINANTS

Chemical [CAS No.] (Documentation date) *Determinant*	*Sampling Time*	*BEI*	*Notation*
Methyl chloroform [71-55-6] (2021)			
Methyl chloroform in end-exhaled air	Prior to shift at end of workweek	20 ppm	—
Methyl chloroform in urine	End of shift	700 µg/L	—
4,4'-Methylene bis(2-chloroaniline) (MBOCA) [101-14-4] (2012)			
Total MBOCA in urine★	End of shift	—	Nq
Methyl ethyl ketone [78-93-3] (2012)			
Methyl ethyl ketone in urine	End of shift	2 mg/L	Ns
Methyl isobutyl ketone [108-10-1] (2009)			
Methyl isobutyl ketone in urine	End of shift	1 mg/L	—
N-Methyl-2-pyrrolidone [872-50-4] (2006)			
5-Hydroxy-N-methyl-2-pyrrolidone in urine	End of shift	100 mg/L	—
Naphthalene [91-20-3] (2012)			
1-Naphthol★ + 2-Naphthol★	End of shift	—	Nq, Ns
Nickel [7440-02-0] and inorganic compounds (2021)			
Nickel in urine after exposure to elemental Nickel and poorly soluble compounds	Post-shift at end of workweek	5 µg/L	B
Nickel in urine after exposure to soluble compounds	Post-shift at end of workweek	30 µg/L	—

ADOPTED BIOLOGICAL EXPOSURE DETERMINANTS

Chemical [CAS No.] (Documentation date) *Determinant*	*Sampling Time*	*BEI*	*Notation*
Nitrobenzene [98-95-3] (2013)			
Methemoglobin in blood	*See* Methemoglobin Inducers BEI	—	—
Parathion [56-38-2] (2019)			
Total p-Nitrophenol in urine	End of shift	0.5 mg/g creatinine	Ns
Acetylcholinesterase activity in red blood cells	End of shift	70% of individual's baseline activity**	Ns
** The average of 2 baseline respective acetylcholinesterase activity determinations 3 days apart, with no exposure to enzyme inhibiting pesticides for at least 30 days, is recommended for each worker prior to exposure to parathion because of large inter-individual differences in published baseline values. To be established at least once a year. Removal from work place exposures is recommended until the acetylcholinesterase activity returns to within 20% of baseline.			
Pentachlorophenol [87-86-5] (2013)			
Pentachlorophenol in urine★	Prior to last shift of workweek	—	Nq
Phenol [108-95-2] (2005)			
Phenol in urine★	End of shift	250 mg/g creatinine	B, Ns
‡ Platinum [7440-06-4] (2023)	(End of shift)		Pop
Platinum in urine	(End of workweek)	(0.01 µg/L)	
Polycyclic aromatic hydrocarbons (PAHs) (2016)			
1-Hydroxypyrene in urine★	End of shift at end of workweek	2.5 µg/L**	B
3-Hydroxybenzo(a)pyrene in urine★	End of shift at end of workweek	—	Nq
** Adjusted for the Pyrene to Benzo(a)pyrene ratio of the PAH mixture to which workers are exposed			

ADOPTED BIOLOGICAL EXPOSURE DETERMINANTS

Chemical [CAS No.] (Documentation date) *Determinant*	*Sampling Time*	*BEI*	*Notation*
2-Propanol [67-63-0] (2005)			
Acetone in urine	End of shift at end of workweek	40 mg/L	B, Ns
Styrene [100-42-5] (2022)			
Mandelic acid plus phenylglyoxylic acid in urine	End of shift	150 mg/g creatinine	Ns
Styrene in urine	End of shift	20 µg/L	—
Tetrachloroethylene [127-18-4] (2008)			
Tetrachloroethylene in end-exhaled air	Prior to shift	3 ppm	—
Tetrachloroethylene in blood	Prior to shift	0.5 mg/L	—
Tetrahydrofuran [109-99-9] (2006)			
Tetrahydrofuran in urine	End of shift	2 mg/L	—
Toluene [108-88-3] (2009)			
Toluene in blood	Prior to last shift of workweek	0.02 mg/L	—
Toluene in urine	End of shift	0.03 mg/L	—
o-Cresol in urine★	End of shift	0.3 mg/g creatinine	B
Toluene diisocyanate-2,4- [584-84-9] or 2,6- [91-08-7] or as a mixture of isomers (2015)			
Toluene diamine in urine★**	End of shift	5 µg/g creatinine	Ns
** Sum of 2,4- and 2,6- isomers			

ADOPTED BIOLOGICAL EXPOSURE DETERMINANTS

Chemical [CAS No.] (Documentation date) *Determinant*	*Sampling Time*	*BEI*	*Notation*
Trichloroethylene [79-01-6] (2007)			
Trichloroacetic acid in urine	End of shift at end of workweek	15 mg/L	Ns
Trichloroethanol in blood★★	End of shift at end of workweek	0.5 mg/L	Ns
Trichloroethylene in blood	End of shift at end of workweek	—	Sq
Trichloroethylene in end-exhaled air	End of shift at end of workweek	—	Sq
Uranium [7440-61-1] (2009)			
Uranium in urine	End of shift	200 μg/L	—
* Xylenes (technical or commercial grades*)	End of shift	0.3 g/g creatinine)	—
[95-47-6; 106-42-3; 108-38-3; 1330-20-7] (2023)			
*Commercial or technical grade xylenes consist of mixtures of isomers and significant amounts of ethyl benzene as indicated under “Properties.” Because ethyl benzene is known to reduce the metabolism of xylenes to methylhippuric acids, the BEI applies to technical or commercial grades of xylenes only.			
Methylhippuric acids in urine**			
**The determinants refer to the total of all isomers of methylhippuric acids.			

*2023 Adoption

★ With hydrolysis ★★ Without hydrolysis; n-Hexane, Methyl n-butyl ketone and Trichloroethylene

2024 NOTICE OF INTENDED CHANGES

These substances, with their corresponding indices, comprise those for which (1) a BEI is proposed for the first time, (2) a change in the adopted index is proposed, (3) retention on the NIC is proposed, or (4) withdrawal of the Documentation and adopted BEI is proposed. In each case, the proposals should be considered trial indices during the period they are on the NIC. These proposals were ratified by the ACGIH Board of Directors and will remain on the NIC for a minimum of one comment period following this ratification. If the Committee neither finds nor receives any substantive data that changes its scientific opinion regarding an NIC BEI, the Committee may then approve its recommendation to the ACGIH Board of Directors for adoption. If the Committee finds or receives substantive data that changes its scientific opinion regarding an NIC BEI, the Committee may change its recommendation to the ACGIH Board of Directors for the matter to be either retained on or withdrawn from the NIC.

Documentation is available for each of these substances and their proposed values.

This notice provides an opportunity for comment on these proposals. Comments or suggestions should be accompanied by substantiating evidence in the form of peer-reviewed literature and forwarded in electronic format to the ACGIH Science Group at science@acgih.org. Please refer to the ACGIH TLV/BEI Development Process on the ACGIH website (acgih.org/science/tlv-bei-guidelines/policies-procedures-presentations/tlv-bei-development/) for a detailed discussion covering this procedure, methods for input to ACGIH, and deadline dates for receiving comments.

Chemical [CAS No.] *Determinant*	*Sampling Time*	*BEI*	*Notation*
† Platinum [7440-06-4]	End of shift		Pop
Platinum in urine	End of workweek	0.01 µg/L	

† 2023 Revision or addition to the Notice of Intended Changes

BEIs

CHEMICAL SUBSTANCES AND OTHER ISSUES UNDER STUDY

The BEI Committee solicits information, especially data, which may assist it in its deliberations regarding the following substances and issues. Comments and suggestions, accompanied by substantiating evidence, preferably in the form of peer-reviewed literature, should be forwarded in electronic format to the ACGIH Science Group at science@acgih.org. In addition, the Committee solicits recommendations for additional substances and issues of concern to the industrial hygiene and occupational health communities. Please refer to the ACGIH TLV/BEI Development Process found on the ACGIH website for a detailed discussion covering this procedure and methods for input to ACGIH (acgih.org/tlv-bei-guidelines/policies-procedures-presentations/tlv-bei-development-process).

The Under Study list is published each year on the ACGIH website (acgih.org/science/tlv-bei-guidelines/documentation-publications-and-data/under-study/) and later in the *TLVs and BEIs* book.

The substances and issues listed below are current as of December 1, 2023. After this date, please refer to the ACGIH website (acgih.org/science/tlv-bei-guidelines/documentation-publications-and-data/under-study) for the up-to-date list.

Chemical Substances

1,3-Butadiene
Antimony
Atrazine
Benzene
Bisphenol-A
Copper
Dibutyl phthalate
Glyphosate
Heptane
Methyl ethyl ketone
Nicotine
Trimethylbenzene

Feasibility Assessments

For the substances listed below, the BEI Committee has determined that developing a BEI is not currently feasible owing to inadequate scientific data. However, the Committee believes that these substances may pose important risks to the health of workers, and therefore, it encourages the submission of new data. Field or experimental studies on the relationship between biological indicators and either health risk or environmental exposure are needed for these agents. A brief summary of the current negative feasibility assessment, including data needs, for each of the listed substances is available from the ACGIH Science Group at science@acgih.org.

Substance	Date of Feasibility Assessment
Acrylonitrile	March 1994
Adipates	July 2023

Alachlor	September 2009
Aluminum	September 2007
Antimony	November 1996
Beryllium	November 2010
1-Bromopropane	April 2017
Chlorpyrifos	October 1996
1,4-Dichlorobenzene	March 1994
3,3'-Dichlorobenzidine	November 2022
2,4-Dichlorophenoxy-acetic acid	March 1994
Diethanolamine	September 2013
Diethylhydroxylamine	September 2021
2-Ethyl hexanoic acid	September 2001
Ethylene glycol	November 2022
Formic acid	June 2023
Hydrazine	March 1994
Inorganic borates	October 1995
Manganese	October 2017
Methyl tert-butyl ether	October 1993
Methyl n-butyl ketone	June 2020
Methylcyclohexane	June 2020
Methyl formate	September 2005
Methyl isobutyl carbinol	June 2020
α-Methylstyrene	November 2010
Nitrobenzene	September 2013
Perfluorooctanoic acid	April 2007
Selenium	October 1995
Styrene oxide	September 2021
Thallium	November 2010
Trimethylbenzene	August 1999
Vanadium pentoxide	September 2009
Vinyl chloride	August 2002

2024
Threshold Limit Values for Physical Agents in the Work Environment

Adopted by ACGIH
with Intended Changes

Contents

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INTRODUCTION TO THE PHYSICAL AGENTS

This section presents Threshold Limit Values (TLVs) for occupational exposure to physical agents of acoustic, electromagnetic, ergonomic, mechanical, and thermal nature. As with other TLVs, those for physical agents provide guidance on the levels of exposure and conditions under which it is believed that nearly all healthy workers may be repeatedly exposed, day after day, without adverse health effects.

The target organs and health effects of these physical agents vary greatly with their nature; thus, TLVs are not single numbers, but rather integrations of the measured parameters of the agent, its effects on workers, or both. Due to the many types of physical agents, a variety of scientific disciplines, detection techniques, and instrumentation are applied. Therefore, it is especially important that the Physical Agents TLVs be applied only by individuals adequately trained and experienced in the corresponding measurement and evaluation techniques. Given the unavoidable complexity of some of these TLVs, the most current Documentation of the Physical Agents TLVs must be consulted when they are applied.

Because of wide variations in individual susceptibility, exposure of an individual at, or even below, the TLV may result in annoyance, aggravation of a pre-existing condition, or physiological effects. Certain individuals may also be more susceptible or otherwise unusually responsive to some physical agents at the workplace because of a variety of factors such as age, sex, genetic factors (predisposition), personal behaviors (e.g., smoking, diet, exercise, abuse of alcohol or other drugs, extracurricular activities – hobbies), medications, and medical conditions (e.g., cardiovascular disease). Some workers may become more susceptible to adverse effects from a physical agent following previous exposures. Concurrent exposures to other physical agents may increase susceptibility. Changes in susceptibility may also occur at different work levels (e.g., light versus heavy work). Maternal and fetal susceptibility to the effects of some physical agents may be altered during different periods of fetal development. Such workers may not be adequately protected from adverse health effects from exposures to certain physical agents at or below the TLVs. An occupational physician should evaluate the extent to which such workers require additional protection.

TLVs are based on available information from industrial experience, from experimental human and animal studies, and when possible, from a combination of the three, as cited in their Documentation.

Like all TLVs, these limits are intended for use in the practice of occupational hygiene and should be interpreted and applied only by a person trained in this discipline. They are not intended for use, or for modification for use (1) in the evaluation or control of the levels of physical agents in the community, or (2) as proof or disproof of an existing physical disability.

These values are reviewed annually by ACGIH for revision or additions as further information becomes available. ACGIH regularly examines the data related to mutagenicity, cancer, adverse reproductive effects, and other health effects of physical agents. Comments, accompanied by substantive documen-

tation, are solicited and should be forwarded in electronic format to the ACGIH Science Group at science@acgih.org.

Notice of Intended Changes

Each year, proposed actions for the forthcoming year are issued in the form of a Notice of Intended Changes (NIC). These physical agents, with their corresponding values, comprise those for which (1) a limit is proposed for the first time, (2) a change in the adopted values is proposed, (3) retention on the NIC is proposed, or (4) withdrawal of the Documentation and adopted TLV is proposed. In each case, the proposals should be considered trial values during the period they are on the NIC. These proposals are ratified by the ACGIH Board of Directors and will remain as NICs for a minimum of one comment period following ratification. If the Committee neither finds nor receives any substantive data that change its scientific opinion regarding physical agent TLVs on the NIC, the Committee may approve its recommendation to the ACGIH Board of Directors for adoption. If the Committee finds or receives substantive data that change its scientific opinion regarding a TLV on the NIC, the Committee may change its recommendation to the ACGIH Board of Directors for the matter to be either retained on or withdrawn from the NIC.

Documentation is available for each of these physical agents and their proposed values.

This notice provides an opportunity for comment on these proposals. Comments or suggestions should be accompanied by substantiating evidence preferably in the form of peer-reviewed literature and forwarded in electronic format to the ACGIH Science Group at science@acgih.org. Please refer to the ACGIH TLV/BEI Development Process on the ACGIH website (acgih.org/tlv-bei-guidelines/policies-procedures-presentations/tlv-bei-development-process) for a detailed discussion covering this procedure, methods for input to ACGIH, and deadline date for receiving comments.

Definitions

TLV categories used in this section include the following:

a) *Threshold Limit Value–Time-Weighted Average (TLV-TWA).* The time-weighted average exposure for an 8-hour workday and 40-hour workweek.
b) *Threshold Limit Value–Ceiling (TLV-C).* Exposure limit that should not be exceeded even instantaneously.

Physical and Chemical Factors

Combinations of such physical factors as heat, ultraviolet and ionizing radiation, humidity, abnormal pressure (altitude), and the like, as well as the interaction of physical factors with chemical substances in the workplace, may place added stress on the body so that the effects from exposure at a TLV may be altered. This stress may act adversely to increase the toxic response to a foreign substance. Although most TLVs have built-in uncertainty factors to guard against adverse health effects when there are moderate deviations from normal environments, the uncertainty factors for most exposures are not of such a

magnitude as to compensate for gross deviations. In such instances, informed professional judgment must be exercised in the proper adjustment of the TLVs.

Unusual Work Schedules

Work schedules markedly different from the traditional 8-hour day, 40-hour workweek require careful judgment in the application of the TLVs. Non-traditional workshifts may result in overexposure and/or limited opportunity to recover prior to re-exposure. Some workers have more than one job, which may result in overexposure, even if neither job by itself entails overexposure. Extrapolation of the TLVs to account for potential overexposure and/or insufficient recovery due to unusual work schedules should be approached with great caution.

ACOUSTIC

* INFRASOUND AND LOW-FREQUENCY SOUND
(Documentation Date – 2023)

Note: Because of the considerable overlap between infrasound and audible low-frequency sound, both values should be considered when dealing with these noises.

These TLVs address worker exposures to sound in the range of 1 to 100 Hz that can cause nonauditory effects on comfort, performance, and health. Exposures to sound in this frequency range can cause vibration of human body biological structures via the airborne transmission of low-frequency acoustical energy. Specifically, infrasound is defined as acoustical energy in the frequency range of 1 to <20 Hz that is not detectable by the human ear. These TLVs represent sound to which it is believed nearly all workers may be repeatedly exposed without adverse health effects that do not involve hearing.

The TLVs do not apply to impulsive sound with durations of <2 seconds. For all other exposures, the TLVs are listed in Table 1. There are no time limits for these exposures. However, application of the TLVs for Audible Sound, recommended to prevent noise-induced hearing loss, may provide a reduced acceptable exposure level with time. This reduction will depend on the amount of attenuation allowed for hearing protection.

TABLE 1. TLVs for Infrasound and Low-Frequency Sound

Sound Pressure Level (SPL)	TLV
Unweighted one-third octave bands between 1 and 100 Hz[a]	145 dB
Unweighted overall between 1 and 100 Hz	150 dB

[a] American National Standards Institute.[1]

Note: Low-frequency sounds have been known to excite resonances in the upper torso of the human body primarily at frequencies between 50 and 100 Hz. Such an effect may cause worker annoyance and discomfort at levels below the TLVs described above and may warrant the reduction to a level where the problem disappears.

1. American National Standards Institute (ANSI). Electroacoustics-octave-band and fractional-octave-band filters – Part 1: Specifications. New York (NY): ANSI. 2014.

AUDIBLE SOUND

(Documentation Date – 2018)

Note: Because of the considerable overlap between infrasound and audible low-frequency sound, both values should be considered when dealing with these noises.

These TLVs refer to sound pressure levels of noise (i.e., unwanted audible sound between the frequencies of 20 and 20,000 Hz) and durations of exposure that represent conditions under which it is believed that nearly all workers may be repeatedly exposed without adverse effect on their ability to hear and understand normal speech. The values should be used as guides in the control of noise exposure and, due to individual susceptibility, should not be regarded as fine lines between safe and dangerous levels.

It should be recognized that the application of the TLVs for noise will not protect all workers from the adverse auditory effects of noise exposure, and also may not protect against a range of non-auditory effects. The TLVs should protect the median of the population against noise-induced hearing loss ≥2 decibels (dB) after 40 years of occupational exposure for the average hearing threshold level across the critical audiometric frequencies of 0.5, 1, 2, and 3 kHz. A hearing conservation program, including key program elements (exposure monitoring, implementation of noise controls, worker training, use of hearing protection devices, recordkeeping, program evaluation, and audiometric testing) is necessary when workers are exposed to noise at or above the TLV levels.

Continuous or Intermittent Noise

The noise level should be determined by a sound level meter, integrating sound level meter, or dosimeter conforming, as a minimum, to the requirements of the American National Standards Institute (ANSI) Sound Level Meter – Part 1: Specifications, S1.4-1 Type 2,[1] ANSI S1.25 – Specification for Personal Noise Dosimeters,[2] or IEC 61672-1.[3] The measurement device should be set to use the A-weighted network (i.e., dBA) with slow meter response. The duration of exposure should not exceed that shown in Table 1. These values apply to total duration of exposure per day regardless of whether this is one continuous exposure or a number of short-term exposures.

When the daily noise exposure is composed of two or more periods of noise exposure of different levels, their combined effect should be considered rather than the individual effect of each. If the sum of the following fractions,

$$\frac{C_1}{T_1}+\frac{C_2}{T_2}+\Lambda\ \frac{C_n}{T_n}$$

exceeds unity, then the combined exposure should be considered to exceed the TLV. C indicates the total duration of exposure at a specific noise level, and T indicates the total duration of exposure permitted at that level. All on-the-job noise exposures of 80 to 140 dBA should be used in the above calculations.

This formula should be used for sounds with limited variability (± 2.5 dB or less) as measured with sound level meters.[4,5] For more variable sound pressure levels and when brief, impulsive or impact sounds are present, a dosimeter or an integrating sound level meter must be used. The limit is exceeded when the dose is more than 100% as indicated on a dosimeter set with a 3 dB time-inten-

sity exchange rate and an 8-hour criteria level of 85 dBA. The TLV is exceeded on an integrating sound level meter when the average noise level over a given duration exceeds the values given in Table 1.

TABLE 1. Threshold Limit Values for Audible Sound[a]

	Duration per day	Sound Pressure level dBA[b]
Hours	24	80
	16	82
	8	85
	4	88
	2	91
	1	94
Minutes	30	97
	15	100
	7.5[c]	103
	3.75[c]	106
	1.99[c]	109
	0.94[c]	112
Seconds[c]	28.12	115
	14.06	118
	7.03	121
	3.52	124
	1.76	127
	0.88	130
	0.44	133
	0.22	136
	0.11	139
	0.08	140

[a] No exposure to continuous, intermittent, or impact noise (e.g., audible sound between the frequencies of 20 and 20,000 Hz) is permitted in excess of a peak C-weighted level of 140 decibels (dB).
[b] Noise levels in decibels are measured on a sound level meter, conforming, as a minimum, to the requirements of the American National Standards Institute Sound Level Meters – Part 1: Specifications, S1.4 Type 2,1 and set to use the A-weighted network with slow meter response.
[c] Limited by engineering control of the noise source if feasible. Administrative control is permissible if engineering control is infeasible.

Impulsive or Impact Noise

Impact and impulse noise involves brief noise excursions that last <1 sec. Impact noise results from colliding objects, causing them to ring. Impulse noise results from explosions or formation of shock waves. Use of the instrumentation specified by ANSI S1.4-1,[1] ANSI S1.25,[2] or IEC 61672-1[3] ensures that impulse noise is integrated into the measured noise level. The only measurement requirements for impulse noise level are that the metering

equipment should have a measurement range between 80 and 140 dBA and a pulse range response of at least 63 dB. No exposures of an unprotected ear in excess of a C-weighted peak sound pressure level of 140 dB are permitted. If instrumentation is not available to measure a C-weighted peak, a Z-weighted[3] or unweighted peak measurement below 140 dB may be used to imply that the C-weighted peak is below 140 dB.

Notes:

1. For audible sound impulses above a C-weighted peak of 140 dB, hearing protection should be worn. The MIL-STD-1474E provides guidance for those situations in which single protection (plugs or muffs) or double protection (both muffs and plugs) should be worn.[6] Additional guidance on appropriate attenuated exposure levels is provided by the European Committee for Standardization.[7]
2. Exposure to certain chemicals may also result in hearing loss and the exacerbation of the effects of noise.[8-10] In settings where there may be exposures to noise and to carbon monoxide, hydrogen cyanide, lead, and solvent mixtures, or exposures to ethylbenzene, styrene, toluene, or xylene in the absence of noise, periodic audiograms are advised and should be carefully reviewed, with the potential confounding effect of noise in mind.[11] Other substances under investigation for ototoxic effects include arsenic, carbon disulfide, chlorobenzene, mercury, nitriles, n-hexane, pesticides, and trichloroethylene.
3. There is evidence to suggest that noise exposure in excess of a C-weighted, 8-hour TWA of 115 dBC or a peak exposure of 155 dBC to the abdomen of pregnant workers beyond the fifth month of pregnancy may cause hearing loss in the fetus.
4. The sum of the fractions of any one day may exceed unity, provided that the sum of the fractions over a 7-day period is 5 or less and no daily fraction is more than 3.
5. Table 1 is based on daily exposures in which there will be time away from the workplace in effective quiet, i.e., <70 dBA. This time away from the workplace will allow any temporary shifts in worker's hearing thresholds to recover. When the worker is restricted for periods of greater than 24 hours to employer-controlled spaces or areas that serve as both workplace and living quarters, the average noise exposure over any 24-hour period should not exceed 80 dBA.
6. There is evidence to suggest that chronic exposures to occupational noise <85 dBA—that is, below that sufficient for a substantially elevated risk of noise-induced hearing loss—may be associated with an increased risk of elevated blood pressure, hypertension, and ischemic heart disease among manufacturing and production workers. The TLV may not be protective against these effects.
7. There is evidence to suggest that noise exposures >85 dBA may be associated with an increased risk of occupational injury through

distraction, stress, fatigue, performance degradation, or other mechanisms among manufacturing and production workers. The TLV may be protective against these effects, though it is possible that acute injury risk is more highly associated with brief excursions rather than an 8-hour average level; if true, this suggests a different risk scenario than those presented for noise-induced hearing loss and cardiovascular disease.

8. While auditory effects of noise are determined largely by signal intensity and frequency, nonauditory effects (e.g., cardiovascular effects and injury risk) may also be influenced by predictability of signal, perceived control, time of day, rise-time, and even information content.

References

1. American National Standards Institute (ANSI). Sound level meters – Part 1: Specifications. ANSI S1.4-1 (2014). New York (NY): ANSI. 2014.

2. American National Standards Institute (ANSI). Specification for Personal Noise Dosimeters. ANSI S1.25-1991 (R2007). New York (NY): ANSI. 2007.

3. International Electrotechnical Commission (IEC). Electroacoustics: Sound level meters – Part 1: Specifications. IEC 61672:1-2013. Geneva (CH): IEC. 2013.

4. American National Standards Institute (ANSI). Measurement of occupational noise exposure. ANSI/ASA S12.19-1996 (R2016). New York (NY): ANSI. 2016.

5. American National Standards Institute (ANSI). Estimation of noise-induced hearing loss: Part 1—Method for calculating expected noise-induced permanent threshold shift. ANSI S3.44-1-2016. New York (NY): ANSI. 2016.

6. US Department of Defense (US DOD). Design criteria standard: noise limits (metric). MIL-STD-1474E. Washington (DC): US DOD. 2015.

7. European Committee for Standardization (CEN). Hearing protectors: Recommendations for selection, use, care and maintenance—Guidance document. EN 458:2004. Brussels (BE): CEN. 2004.

8. European Agency for Safety and Health at Work (EU OSHA). Combined exposures to noise and ototoxic substances. Luxembourg (LU): EU OSHA. 2009. [accessed November 23, 2022.] https://osha.europa.eu/en/tools-and-publications/publications/literature_reviews/combined-exposure-to-noise-and-ototoxic-substances.

9. Johnson AC, Morata TC. 142. Occupational exposure to chemicals and hearing impairment. The Nordic Expert Group for Criteria Documentation of Health Risks from Chemicals, Nordic Expert Group. Gothenburg (SE): University of Gothenburg. 2010. [accessed November 23, 2022.] https://gupea.ub.gu.se/handle/2077/23240. Accessed: 11/1/2016.

10. Choi YH, Kim K. Noise-induced hearing loss in Korean workers: co-exposure to organic solvents and heavy metals in nationwide industries. PLos One. 2014; 9(5):e97538.

11. Nies E. Ototoxic substances at the workplace: a brief update. Arh Hig Rada Toksikol. 2012; 63(2):147-152.

ULTRASOUND

(Documentation Date – 2001)

These TLVs represent conditions under which it is believed that nearly all workers may be repeatedly exposed without adverse effect on their ability to hear and understand normal speech. Previous TLVs for the frequencies 10 kilohertz (kHz) to 20 kHz, et to prevent subjective effects, are referenced in a cautionary note to Table 1. The 8-hour TWA values are an extension of the TLV for Noise, which is an 8-hour TWA of 85 dBA. The ceiling values may be verified by using a sound level meter with slow detection and 1/3 octave bands. The TWA values may be verified by using an integrating sound level meter with 1/3 octave bands. All instrumentation should have adequate frequency response and should meet the specifications of ANSI S1.4-1983 (R1997)[1] and IEC 804.[2]

TABLE 1. TLVs for Ultrasound

	One-third Octave-Band Level		
	Measured in Air in dB Re: 20 µPa; Head in Air		Measured in Water in dB re: 1 µPa; Head in Water
Mid-frequency of Third-Octave Band (kHz)	Ceiling Values	8-h TWA	Ceiling Values
10	105[a]	88[a]	167
12.5	105[a]	89[a]	167
16	105[a]	92[a]	167
20	105[a]	94[a]	167
25	110[b]	—	172
31.5	115[b]	—	177
40	115[b]	—	177
50	115[b]	—	177
63	115[b]	—	177
80	115[b]	—	177
100	115[b]	—	177

[a] Subjective annoyance and discomfort may occur in some individuals at levels between 75 and 105 dB for the frequencies from 10 kHz to 20 kHz especially if they are tonal in nature. Hearing protection or engineering controls may be needed to prevent subjective effects. Tonal sounds in frequencies below 10 kHz might also need to be reduced to 80 dB.

[b] These values assume that human coupling with water or other substrate exists. These thresholds may be raised by 30 dB when there is no possibility that the ultrasound can couple with the body by touching water or some other medium. (When the ultrasound source directly contacts the body, the values in the table do not apply. The vibration level at the mastoid bone must be used.) Acceleration values 15 dB above the reference of 1 g rms should be avoided

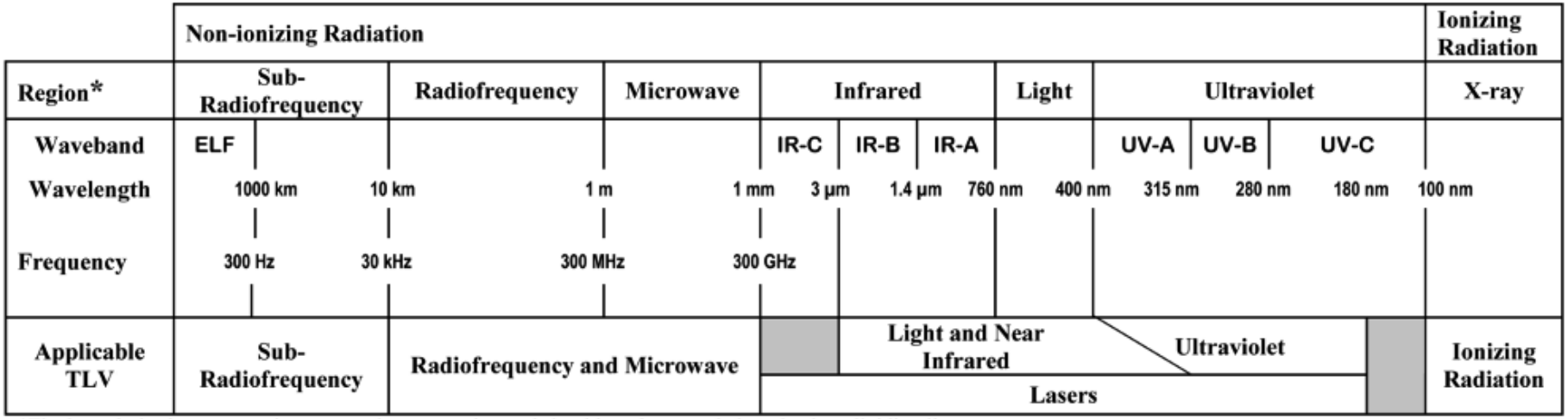
by reduction of exposure or isolation of the body from the coupling source (g = acceleration due to the force of gravity, 9.80665 meters/second^2; rms = root-mean-square).

Source: American National Standards Institute.[3]

References

1. American National Standards Institute. Specification for sound level meters. ANSI S1.4-1983 (R1997). New York (NY): ANSI. 1997.
2. International Electrotechnical Commission: Integrating-Averaging Sound Level Meters. IEC 804. New York (NY): IEC. 1985.
3. American National Standards Institute. Specification for octave-band and fractional-octave-band analog and digital filters S1.11-1986 (R1998). New York (NY): ANSI. 1998.

ELECTROMAGNETIC RADIATION SPECTRUM AND RELATED TLVS



*The boundaries between regions are set by convention and should not be regarded as absolute dividing lines.

TLV-PA

ELECTROMAGNETIC FIELDS 0–300 GHz

STATIC MAGNETIC FIELDS
(Documentation Date – 2015)

These TLVs refer to static magnetic field flux densities to which it is believed that nearly all workers may be repeatedly exposed day after day without adverse health effects. These values should be used as guides in the control of exposure to static magnetic fields and should not be regarded as fine lines between safe and dangerous levels.

Routine occupational exposures should not exceed 2 tesla (T) in the general workplace environment, but can have ceiling values of 8 T for workers with special training and operating in a controlled workplace environment. Special training involves making workers aware of transient sensory effects that can result from rapid motion in static magnetic fields with flux densities greater than 2 T. A controlled workplace environment is one in which forces exerted by static magnetic fields on metallic objects do not create potentially hazardous projectiles. Exposure of the limbs of workers in the general workplace environment should not exceed 20 T. Workers with implanted ferromagnetic or electronic medical devices should not be exposed to static magnetic fields exceeding 0.5 mT.

These TLVs are summarized in Table 1.

TABLE 1. TLVs for Static Magnetic Fields

Exposure	Ceiling Value
Whole body (general workplace)	2 T
Whole body (special worker training and controlled workplace environment)	8 T
Limbs	20 T
Medical device wearers	0.5 mT

SUB-RADIOFREQUENCY (30 kHz and below) MAGNETIC FIELDS

(Documentation Date – 2017)

These TLVs refer to the amplitude of the magnetic flux density (B) of sub-radiofrequency (sub-RF) magnetic fields in the frequency range of 30 kilohertz (kHz) and below to which it is believed that nearly all workers may be exposed repeatedly without adverse health effects. The magnetic field strengths in these TLVs are root-mean-square (rms) values. These values should be used as guides in the control of exposure to sub-radiofrequency magnetic fields and should not be regarded as fine lines between safe and dangerous levels.

Occupational exposures in the extremely-low-frequency (ELF) range from 1 to 300 hertz (Hz) should not exceed the ceiling value given by the equation:

$$B_{TLV} = \frac{60}{\mathrm{f}}$$

where: f = the frequency in Hz

B_{TLV} = the magnetic flux density in millitesla (mT).

For frequencies in the range of 300 Hz to 30 kHz (which includes the voice frequency [VF] band from 300 Hz to 3 kHz and the very-low-frequency [VLF] band from 3 to 30 kHz), occupational exposures should not exceed the ceiling value of 0.2 mT.

These ceiling values for frequencies of 300 Hz to 30 kHz are intended for both partial-body and whole-body exposures. For frequencies below 300 Hz, the TLV for exposure of the extremities can be increased by a factor of 10 for the hands and feet and by a factor of 5 for the arms and legs.

The magnetic flux density of 60 mT/f at 60 Hz corresponds to a maximum permissible flux density of 1 mT. At 30 kHz, the TLV is 0.2 mT, which corresponds to a magnetic field intensity of 160 amperes per meter (A/m).*

Contact currents from touching ungrounded objects that have acquired an induced electrical charge in a strong sub-RF magnetic field should not exceed the following point contact levels to avoid startle responses or severe electrical shocks:

A. 1.0 milliampere (mA) at frequencies from 1 Hz to 2.5 kHz;
B. 0.4 f mA at frequencies from 2.5 to 30 kHz, where f is the frequency expressed in kHz.

* Magnetic fields are expressed in units of amperes/m. In health and safety studies, a more common dosimetric quantity is the magnetic flux density in units of Tesla (T) or Gauss (G). 1 T = 10,000 G. The two quantities are related by the magnetic permeability of the medium. In air, 1 A/m corresponds to a flux density of 1.3 μT.

Notes:

1. These TLVs are based on an assessment of available data from laboratory research and human exposure studies. Modifications of the TLVs will be made if warranted by new information. At this time, there is insufficient information on human responses and possible health effects of magnetic fields in the frequency range of 1 Hz to 30 kHz to permit the establishment of a TLV for time-weighted average exposures.
2. For workers wearing cardiac pacemakers, the TLV may not protect against electromagnetic interference with pacemaker function. Some models of cardiac pacemakers have been shown to be susceptible to interference by power-frequency (50/60 Hz) magnetic flux densities as low as 0.1 mT. It is recommended that, lacking specific information on electromagnetic interference from the manufacturer, the exposure of persons wearing cardiac pacemakers or similar medical electronic devices be maintained at or below 0.1 mT at power frequencies.
3. Fields in excess of the TLV are likely to be present only in close proximity to high powered electrical equipment; in most occupational environments sub-RF fields are likely to be far below the TLV. There should consequently be little need for detailed field surveys in general occupational spaces, although such surveys may help to address workers' concerns. If field surveys are undertaken, however, they should use appropriate equipment that has been calibrated and suitable for the anticipated measurements. In particular, unless they are designed for such measurements, magnetic field meters can be significantly in error when used to measure nonsinusoidal waveforms or fields at frequencies other than 50/60 Hz.

TABLE 1. TLVs for Sub-Radiofrequency (30 kHz and below) Magnetic Fields

Frequency Range	TLV
1 to 300 Hz	Whole-body exposure: $\frac{60}{f}$ ceiling value in mT[a] Arms and legs: $\frac{300}{f}$ ceiling value in mT[a] Hands and feet: $\frac{600}{f}$ ceiling value in mT[a]
300 Hz to 30 kHz	Whole-body and partial-body ceiling value: 0.2 mT
1 Hz to 2.5 kHz	Point contact current limit: 1.0 mA
2.5 to 30 kHz	Point contact current limit: 0.4 f mA[b]

[a] f = frequency in Hz
[b] f = frequency in kHz

SUB-RADIOFREQUENCY (30 kHz and below) and STATIC ELECTRIC FIELDS

(Documentation Date – 2016)

These TLVs refer to the maximum workplace field strengths of sub-radiofrequency electric fields (30 kHz and below) and static electric fields that represent conditions under which it is believed that nearly all workers may be exposed repeatedly without special protection without adverse health effects. The electric field intensities in these TLVs are root-mean-square (rms) values. The values should be used as guides in the control of exposure and should not be regarded as a fine line between safe and dangerous levels. The electric field strengths stated in these TLVs refer to the field levels present in air, away from the surfaces of conductors (where spark discharges and contact currents may pose significant hazards).

Occupational exposures should not exceed a field strength of 25 kilovolts per meter (kV/m) at frequencies from 0 Hz to 220 Hz. For frequencies in the range of 220 Hz to 3 kilohertz (kHz), the ceiling value is given by:

$$E_{TLV} = 5.525 \times 10^6/f$$

where:

f = the frequency in Hz
E_{TLV} = the rms electric field strength in V/m

A rms value of 1842 V/m is the ceiling value for frequencies from 3 to 30 kHz. These ceiling values are intended for both partial-body and whole-body exposures.

Notes:

1. These TLVs are based on limiting field-induced effects at the body surface and induced currents within the body to levels below those that are believed to be hazardous. These are direct effects.
2. Indirect effects associated with touching charged objects within the electric field can be the limiting phenomena that determine safe practice. A noticeable and potentially annoying spark discharge can be experienced beneath power lines when the ground level field strength is at or below 5 kV/m.[1] Mitigation of such effects requires compliance with safe work practices and electrical safety codes beyond the scope of this TLV.
3. Certain biological effects have been reported in laboratory studies at electric field strengths below those permitted in the TLV; however, there is no convincing evidence at the present time that occupational exposure to such field levels leads to adverse health effects.

Modifications of the TLVs will be made if warranted by new information. At this time, there is insufficient information on human responses and possible health effects of electric fields in the frequency range of 0 to 30 kHz to permit the establishment of a TLV for time-weighted average exposures.

Reference

1. Electrical Power Research Institute (EPRI). AC transmission line reference book: 200 kV and above. (3rd ed.) Palo Alto (CA): EPRI. 2005.

RADIOFREQUENCY/MICROWAVE RADIATION

(Documentation Date – 2016)

These TLVs refer to radiofrequency (RF) radiation in the frequency range of 30 kilohertz (kHz) to 300 gigahertz (GHz). This includes microwave radiation (300 MHz–300 GHz), which is a region of the RF spectrum. These TLVs represent conditions under which it is believed nearly all workers may be repeatedly exposed without adverse health effects.

The TLVs were designed to limit electrostimulation of nerve and muscle tissue at frequencies from 0.03 to 0.1 MHz, and tissue heating above 0.1 MHz. The TLVs are given in terms of root-mean-square (rms) electric (E), and magnetic (H) field strengths, the equivalent plane-wave free-space power densities (S), and induced currents (**I**) in the body.

The TLVs are summarized in Table 1 as a function of frequency, f, in megahertz (MHz). Table 2 summarizes the major dosimetric quantities in different frequency ranges specified in the TLV, and major hazard mechanisms and typical exposure scenarios that would be of concern.

A. For exposures to electric and magnetic free fields, TLVs in Table 1, Part A refer to exposure values obtained by spatially averaging over an area equivalent to the vertical cross-section of the human body (projected area). In the case of partial body exposure, the TLVs can be relaxed. In nonuniform fields, spatial peak values of field strength may exceed the TLVs if the spatially averaged specific absorption rate (SAR) value remains within the specified limits.

B. Access should be restricted to limit the rms RF body current and potential for RF electrostimulation ("shock," below 0.1 MHz) or perceptible heating (at or above 0.1 MHz) as follows (*see* Table 1, Part B):

1. For freestanding individuals (no contact with metallic objects), RF current induced in the human body, as measured through either foot, should not exceed the following values, where f is the frequency in MHz:

   I = 1,000 f mA for (0.03 < f < 0.1 MHz) averaged over 0.2 s;
   where mA = milliampere

   I = 100 mA for (0.1 < f < 100 MHz) averaged over 6 min

2. For conditions of possible contact with metallic bodies, the maximum RF current that can be passed into the body as measured with a contact current meter should not exceed the following values:

   I = 1,000 f mA for (0.03 < f < 0.1 MHz) (where f is the frequency in MHz) averaged over 0.2 s

   I = 100 mA for (0.1 < f < 100 MHz) averaged over 6 min

TABLE 1. Radiofrequency and Microwave TLVs

Part A—Electromagnetic Fields[a] (f = frequency in MHz)

Frequency	Power Density, S (W/m2)	Electric Field Strength E (V/m)	Magnetic Field Strength H (A/m)	Averaging Time E^2, H^2, or S (min)
30-100 kHz		1,842	163	6
100 kHz-1 MHz		1,842	16.3/f	6
1-30 MHz		1,840/f	16.3/f	6
30-100 MHz		61.4	16.3/f	6
100-300 MHz	10	61.4	0.163	6
300 MHz-3 GHz	f/30			6
3-30 GHz	100			$34{,}000/f^{1.079}$
30-300 GHz	100			$68/f^{0.476}$

[a] The exposure values in terms of electric and magnetic field strengths are obtained by spatially averaging over an area equivalent to the vertical cross-section of the human body (projected area). At frequencies between 100 and 300 MHz, the TLV is defined in the near field of the source in terms of electric and magnetic field, and in the far field in terms of the power density of the way. At frequencies above 30 GHz, the power density TLV is the limit of exposure averaged over any contiguous 0.01 m^2 of body surface. However aboe 30 GHz, the maximum power density is 1,000 W/m^2 in any 1 square centimeter.

Part B—Maximum Induced and Contact Radiofrequency Currents (mA)[b]

Frequency	Through Both Feet	Through Either Foot	Grasping[c]	Averaging Time
30-100 kHz	2,000 f	1,000 f	1,000 f	0.2 s[d]
100 KHz-100 MHz	200	100	100	6 min[e]

[b] It should be noted that the current limits given above may not adequately protect against startle reactions and burns caused by transient discharges when contacting an energized object. The ceiling value for induced and contact currents is 500 mA for no more than 15 seconds per 6-min period.

[c] Maximum touch current is limited to 50% of the maximum grasping current.

[d] **I** is averaged over a 0.2-second period.

[e] **I** is averaged over a 6-minute period (e.g., for either foot or hand contact, i.e., **I** t <60,000 mA^2-min). In this table, f is the frequency in Hertz.

3. For touch contact with conductive objects, the maximum RF current should not exceed more than one-half of the maximum RF current for grasping contact. The means of compliance with these current limits can be determined by the user of the TLVs as appropriate. The use of protective gloves, the avoidance of touch contact with conductive objects, the prohibition of metallic objects, or training of personnel may be sufficient to ensure compliance with these TLVs. Evaluation of the magnitude of the induced currents will normally require a direct measurement. However, induced and contact current measurements are not required if the spatially averaged electric field strength does not exceed the TLV given in Table 1, Part A at frequencies between 0.1 and 100 MHz, as shown graphically in Figure 2.

C. For source frequencies greater than 100 MHz, Table 1, Part A provides an equivalent plane-wave power density, S (in W/m^2), which can be calculated from field strength measurement data as follows:

$$S = \frac{E^2}{377}$$

where: E^2 is in volts squared (V^2) per meter squared (m^2); and

$$S = 377\ H^2$$

where: H^2 is in amperes squared (A^2) per meter squared (m^2).

D. For exposures to pulsed fields of pulse duration less than 100 milliseconds (ms) at frequencies in the range 0.1 MHz to 300 GHz, the total incident energy density during any 100 ms period within the averaging time (see Table 1, Part A) shall not exceed 20% of the total specific energy absorption (SA) permitted during the entire averaging time for a continuous field, i.e., $0.2 \times 144 = 28.8$ J/kg. For pulse durations greater than 100 ms, normal time-averaging calculations apply.

The TLV values in Table 1 should be used as guides in the evaluation and control of exposure to radiofrequency and microwave radiation and should not be regarded as fine lines between safe and dangerous levels. The values of E, H and S given in Table 1, Part A are shown graphically as a function of frequency in Figure 1. Figure 2 depicts the maximum permissible current values given in Table 1, Part B through one foot or touch current as a function of the maximum permissible electric field strength TLV over the frequency range 0.1 to 100 MHz.

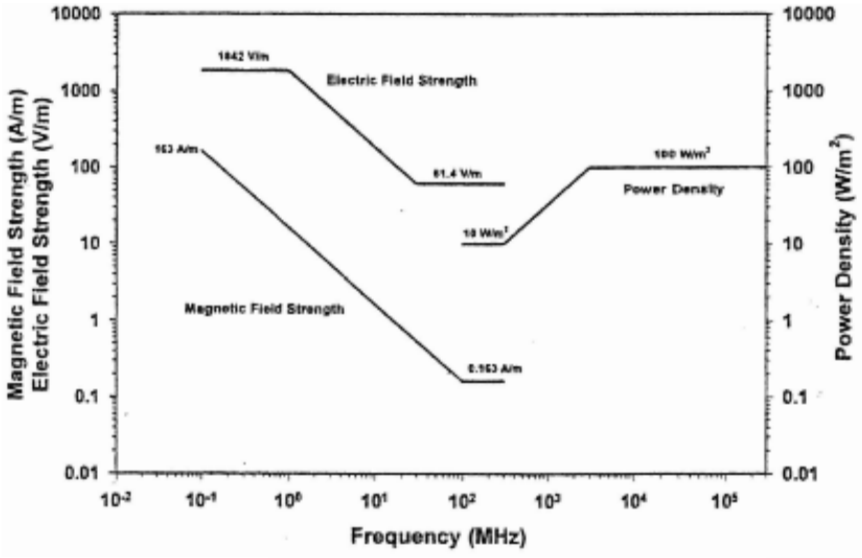


FIGURE 1. Threshold Limit Values (TLVs) for radiofrequency/microwave radiation in the workplace (for whole-body specific absorption rate [SAR] <0.4 W/kg). (From IEEE.[1] Copyright © IEEE. All Rights Reserved).

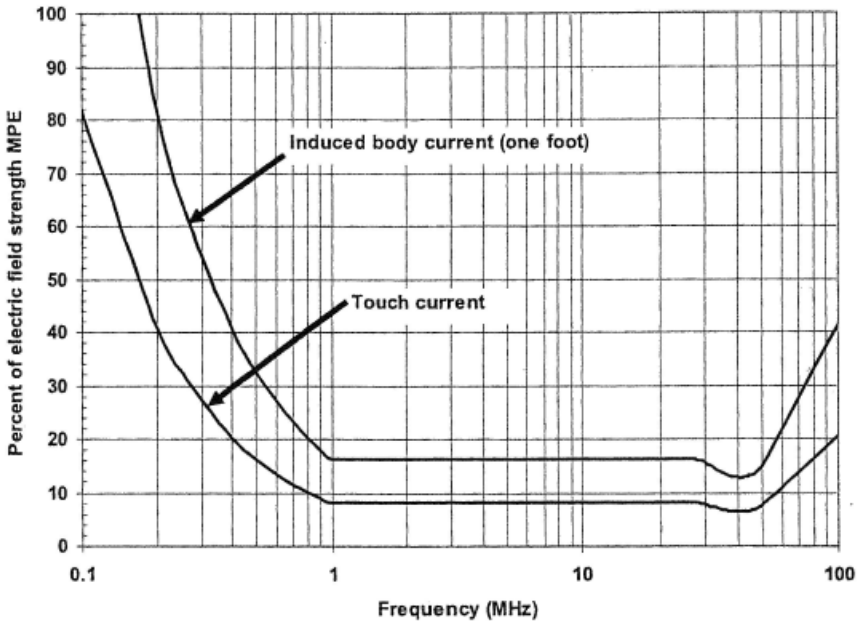


FIGURE 2. Percent of electric field strength TLVs below which induced and contact current limits are *not* required from 0.1 to 100 MHz. (From IEEE,[1] Copyright © IEEE. All Rights Reserved).

Notes:

1. It is believed that workers may be exposed repeatedly to fields up to these TLVs without adverse health effects. Nevertheless, personnel should not needlessly be exposed to higher levels of RF radiation, approaching the TLVs, when simple measures can prevent it.
2. For mixed or broadband fields at a number of frequencies for which there are different values of the TLV, the fraction of the TLV (in terms of E^2, H^2, or S) incurred within each frequency interval should be determined and the sum of all such fractions should not exceed unity.
3. The TLVs refer to values averaged over any 6-minute (0.1-h) period for frequencies less than 3 GHz, and over shorter periods for higher frequencies down to 10 seconds at 300 GHz, as indicated in Table 1, Part A.
4. At frequencies between 0.1 and 3 GHz, the TLVs for electromagnetic field strengths may be exceeded if:
   a) the exposure conditions can be shown by appropriate techniques to produce SARs below 0.4 W/kg, as averaged over the whole body;
   b) the induced currents in the body conform with the TLVs in Table 1, Part B; and
   c) spatial peak SAR values do not exceed 10 W/kg, as averaged over any cubic volume with 10 g of tissue, except for the hands, wrists, feet, ankles, and pinnae, where the spatial peak SAR exposure should not exceed 20 W/kg averaged over any cubic volume of tissue containing 10 g. The SARs are to be averaged over 6 minutes.
5. Above 3 GHz, relaxation of the TLV conditions may be permissible under partial body exposure conditions.
6. The measurement of RF field should follow the recommendations given in IEEE C95.3-2021.[2]

References

1. Institute of Electrical and Electronic Engineers (IEEE). IEEE Standard for safety levels with respect to human exposure to radio frequency electromagnetic fields, 3 kHz to 300 GHz. IEEE C95.1-2005. New York (NY): IEEE. 2005.
2. Institute of Electrical and Electronic Engineers (IEEE). IEEE Recommended practice for measurements and computations of radiofrequency electromagnetic fields with respect to human exposure to such fields, 100 kHz-300 GHz. IEEE C95.3-2021. New York (NY): IEEE. 2021.

TABLE 2. Major Frequency Ranges Covered by the TLV

	Part A- Frequency Range			
	30 kHz-100 kHz	**100 kHz-100 MHz**	**100 MHz-300 MHz[a]**	**300 MHz-300 GHz**
Electric field	X	X	X	
Magnetic field	X	X	X	
Power density		X	X	X
Contact current	X	X[b]		

	Part B - Hazard Mechanism			
	Electrical Stimulation	**Thermal**	**Thermal**	
Typical cause of injury	Contact current (current introduced into body from touching a charged conductor)	Contact current/possible RF heating of deeper tissues	RF heating of tissues	
Typical injury	Electric shock (sometimes burns)	Burns (can be deep in tissue) Excessive whole body heating/ heat stress		
Example sources with potential overexposure	AM radio transmission tower	RF heat sealers and FM transmitting antennae	High-powered broadcasting transmitting antennae (e.g., TV)	Industrial microwave heating equipment, high-powered transmitting antennae

[a] Power density measurements should be made in the far field of the source; otherwise, measurements should be made of electric and magnetic field as appropriate.

[b] Measure contact current if the electric field is greater than the % of E-TLV for that frequency (see Figure 2).

OPTICAL RADIATION

LIGHT AND NEAR-INFRARED RADIATION

(Documentation Date – 2015)

These TLVs refer to values for incoherent (non-laser) visible and near-infrared radiation (LNIR) in the wavelength region of 305 to 3000 nm that nearly all workers may be exposed without adverse health effects. The values are based on the best available information from experimental studies. They should be used only as guides in the control of exposures to light and should not be regarded as fine lines between safe and dangerous levels. For purposes of specifying these TLVs, the optical radiation spectrum is divided into the regions shown in the figure "The Electromagnetic Radiation Spectrum and Related TLVs" found at the beginning of the section on Electromagnetic Fields 0–300 GHz.

Recommended Values

The TLVs for occupational exposure of the eyes to broadband light and near-infrared radiation apply to exposures in any 8-hour workday. Table 1 provides examples of sources and the applicable TLV. Figure 1 is a guide to the application of the TLVs for visible and near-infrared sources.

The LNIR TLVs are divided into four potential health effects and spectral regions as follows:

Section 1. *To protect against retinal photo-chemical injury from chronic blue-light (305 < λ < 700 nm) exposure:* Determine the effective radiance of the light source (L_B) in W • cm^{-2} • sr^{-1} by integrating the spectral radiance (L_λ) in W • cm^{-2} • sr^{-1} • nm^{-1} weighted by the blue-light hazard function B(λ) using Equation 1 or a light meter with a B(λ) filter. B(λ) is shown in Figure 2 and values are provided in Table 2.

$$L_B\,[W \bullet cm^{-2} \bullet sr^{-1}] = \sum_{305}^{700} L_\lambda \bullet B(\lambda) \bullet \Delta\lambda \qquad \textbf{(1)}$$

Some meters provide a total energy emitted in units of J • cm^{-2} • sr^{-1} over the sampling period, which is the time integral of L_B over the sampling period. L_B is the total energy divided by the sample period.

For viewing durations (t) less than 10^4 s (167 mins or ~2.8 hrs) in a day, an acceptable exposure is present when:

$$L_B\,[W \bullet cm^{-2} \bullet sr^{-1}] \leq 100 \bullet t^{-1} \qquad \textbf{(2a)}$$

Alternatively, when L_B exceeds 0.01 W • cm^{-2} • sr^{-1}, the maximum acceptable exposure duration t_{max} in seconds is:

$$t_{max}\,[s] = 100(L_B)^{-1} \qquad \textbf{(2b)}$$

TABLE 1. Example Sources of Non-Laser Optical Radiation and Applicable TLVs

Source Type[a]	Arc Sources Arc welding; Arc lamps; Xenon-arc searchlights	Discharge Lamps	Fluorescent Lamps and LEDs White light and "black light" fluorescent lamps; Visible or UV-A LEDs	Thermal Sources Hot and molten metals; Gas welding; Incandescent lamps; IR LEDs	Germicidal Lamps Low-pressure Mercury Discharge Lamps; UV-B and UV-C Lamps and LEDs
Ultraviolet (see UV TLV)	XX	X	X		XX
Blue-light (see LNIR Section 1)	XX	XX	X		
IR Cornea/lens (see LNIR Section 2)	X	X		XX	
Infrared retina (see LNIR Section 3)	f	f	X		
Retinal thermal (see LNIR Section 4)	M				

XX = Likely; X = possible; f = applicable when filtered lamp blocks visible emission; M = only if magnified source size (e.g., searchlight or projection optics).

[a] A special type of diode emitter, the super-luminescent diode (SLD), although not a laser, should be assessed with the latest laser TLV.

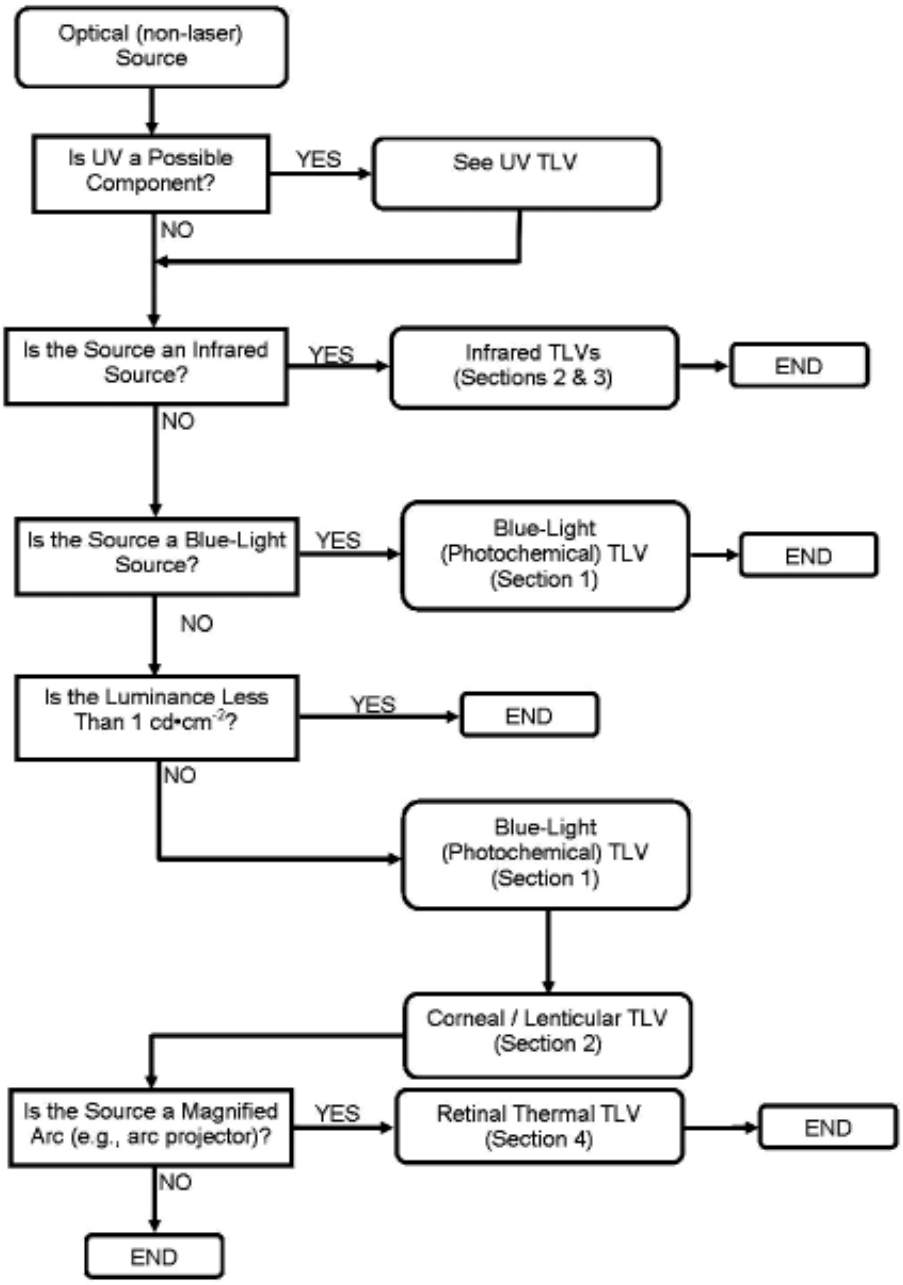


FIGURE 1. Evaluation scheme for visible and near-infrared radiation.

For viewing durations greater than 10^4 s (167 mins) in a day, an acceptable exposure is present when:

$$L_B\,[W \cdot cm^{-2} \cdot sr^{-1}] \leq 10^{-2} \qquad \textbf{(2c)}$$

Note for blue-light hazard: The L_B limits are greater than the maximum permissible exposure limits for 440 nm laser radiation (*see* Laser TLV) because of the need for caution related to narrow-band spectral effects of lasers.

Special Case for Small-Source Angles: For a light source subtending an angle less than 0.011 radian, the above limits are relaxed. Determine the effective irradiance (E_B) by integrating the spectral irradiance (E_λ) weighted by the blue-light hazard function $B(\lambda)$:

$$E_B\,[W \cdot cm^{-2}] = \sum_{305}^{700} E_\lambda \cdot B(\lambda) \cdot \Delta\lambda \qquad \textbf{(3)}$$

For durations less than 100 s (1 min, 40 s) in a day, an acceptable exposure is present when:

$$E_B\,[W \cdot cm^{-2}] = 0.01 \cdot t^{-1} \qquad \textbf{(4a)}$$

Alternatively, for a source where the blue-light weighted irradiance E_B exceeds 10^{-4} W • cm^{-2}, the maximum acceptable exposure duration, t_{max}, in seconds is:

$$t_{max}\,[s] = 0.01 \cdot (E_B)^{-1} \qquad \textbf{(4b)}$$

For viewing durations greater than 10^2 s (1 min, 40 s) in a day, an acceptable exposure is present when:

$$E_B\,[W \cdot cm^{-2}] \leq 10^{-4} \qquad \textbf{(4c)}$$

Special Case: To protect the worker having a lens removed (cataract surgery) against retinal photochemical injury from chronic exposure: Unless an ultraviolet (UV)-absorbing intraocular lens has been surgically inserted into the eye, the Aphakic Hazard Function, $A(\lambda)$, should be used for L_B and E_B, as shown in Equations 5a and 5b.

$$L_B\,[W \cdot cm^{-2} \cdot sr^{-1}] = \sum_{305}^{700} L_\lambda \cdot A(\lambda) \cdot \Delta\lambda \qquad \textbf{(5a)}$$

$$E_B\,[W \cdot cm^{-2}] = \sum_{305}^{700} E_\lambda \cdot A(\lambda) \cdot \Delta\lambda \qquad \textbf{(5b)}$$

The value for L_B is used in Equation 2 and the value for E_B is used in Equation 4.

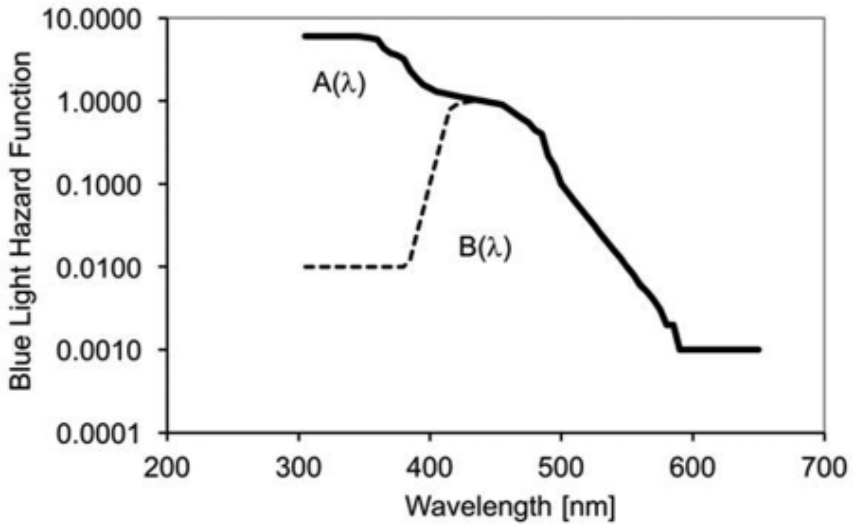


FIGURE 2. Blue-light (retinal photochemical) hazard function for normal eyes [B(λ)] and the aphakic hazard function [A(λ)].

Section 2. *To protect against thermal injury to the cornea and lens from infrared (IR) radiation:* To avoid thermal injury of the cornea and possible delayed effects on the lens of the eye (cataractogenesis), the total infrared irradiance in hot environments is calculated as:

$$E_{IR-only}[W \cdot cm^{-2}] = \sum_{770}^{3000} E_{\lambda} \cdot \Delta\lambda \qquad \textbf{(6)}$$

For exposure durations (t) less than 10^3 sec (17 mins), an acceptable exposure is present when:

$$E_{IR-only}[W \cdot cm^{-2}] \leq 1.8 \cdot t^{-0.75} \qquad \textbf{(7a)}$$

For exposure durations greater than 10^3 sec (17 mins), an acceptable exposure is present when:

$$E_{IR-only}[W \cdot cm^{-2}] \leq 0.01 \qquad \textbf{(7b)}$$

Section 3. *To protect against retinal thermal injury from near-infrared (NIR) radiation:* For a near-infrared source associated with an infrared heat lamp or any NIR source where a strong visual stimulus is absent (luminance less than 10^{-2} cd • cm^{-2}), the total effective radiance (L_{NIR}) as viewed by the eye is the integrated spectral radiance (L_{λ}) weighted by the thermal hazard function, R(λ).

$$L_{NIR}[W \cdot cm^{-2} \cdot sr^{-1}] = \sum_{770}^{1400} L_{\lambda} \cdot R(\lambda) \cdot \Delta\lambda \qquad \textbf{(8)}$$

TABLE 2. Retinal and UVR Hazard Spectral Weighting Functions

Wavelength	Aphakic Hazard Function (Aλ)	Blue-Light Hazard Function (Aλ)	Retinal Thermal Hazard Function (Rλ)
305-335	6.000	0.01	–
340	5.880	0.01	–
345	5.710	0.01	–
350	5.460	0.01	–
355	5.220	0.01	–
360	4.620	0.01	–
365	4.290	0.01	–
370	3.750	0.01	–
375	3.560	0.01	–
380	3.190	0.01	0.01
385	2.310	0.0125	0.125
390	1.880	0.025	0.025
395	1.580	0.050	0.050
400	1.430	0.100	0.100
405	1.300	0.200	0.200
410	1.250	0.400	0.400
415	1.200	0.800	0.800
420	1.150	0.900	0.900
425	1.110	0.950	0.950
430	1.070	0.980	0.980
435	1.030	1.000	1.00
440	1.000	1.000	1.00
445	0.970	0.970	1.00
450	0.940	0.940	1.00
455	0.900	0.900	1.00
460	0.800	0.800	1.00
465	0.700	0.700	1.00
470	0.620	0.620	1.00
475	0.550	0.550	1.00
480	0.450	0.450	1.00
485	0.400	0.400	1.00
490	0.220	0.220	1.00

TABLE 2 (cont.). Retinal and UVR Hazard Spectral Weighting Functions

Wavelength	Aphakic Hazard Function (Aλ)	Blue-Light Hazard Function (Aλ)	Retinal Thermal Hazard Function (Rλ)
495	0.160	0.160	1.00
500	0.100	0.100	1.00
505	0.079	0.079	1.00
510	0.063	0.063	1.00
515	0.050	0.050	1.00
520	0.040	0.040	1.00
525	0.032	0.031	1.00
530	0.025	0.025	1.00
535	0.020	0.020	1.00
540	0.016	0.016	1.00
545	0.013	0.013	1.00
550	0.010	0.010	1.00
555	0.008	0.008	1.0
560	0.006	0.006	1.0
565	0.005	0.005	1.0
570	0.004	0.004	1.0
575	0.003	0.003	1.0
580	0.002	0.002	1.0
585	0.002	0.002	1.0
590	0.001	0.001	1.0
595	0.001	0.001	1.0
600-700	0.001	0.001	1.0
700-1,050	–	–	$10^{\{(700-\lambda)/500\}}$
1,050-1,150	–		0.2
1,150-1,200	–		$0.2 \times 10^{\{0.02(1,150-1)\}}$
1,200-1,400	–		0.02

TLV-PA

Limits for IR only exposures are based on a 7-mm pupil diameter (since the aversion response may not exist due to an absence of light) and a detector field-of-view of 0.011 rad. For exposures less than 810 s, an acceptable exposure is present when:

$$L_{NIR}\,[W \cdot cm^{-2} \cdot sr^{-1}] < 3.2 \cdot \alpha^{-1} \cdot t^{-0.25} \qquad \textbf{(9a)}\blacklozenge$$

For exposures greater than 810 s in a day, an acceptable exposure is present when:

$$L_{NIR}\,[W \cdot cm^{-2} \cdot sr^{-1}] \leq 0.6 \cdot \alpha^{-1} \qquad \textbf{(9b)}\blacklozenge$$

Section 4. *To protect against retinal thermal injury from a visible light source:* Determine the effective radiance of the lamp (L_R) in W • cm^{-2} • sr^{-1} [sr = steradian] by integrating the spectral radiance (L_λ) in W • cm^{-2} • sr^{-1} • nm weighted by the thermal hazard function R(λ), using Equation 10 or a light meter with an R(λ) filter. R(λ) is shown in Figure 3.

$$L_R\,[W \cdot cm^{-2} \cdot sr^{-1}] = \sum_{380}^{1400} L_\lambda \cdot R(\lambda) \cdot \Delta\lambda \qquad \textbf{(10)}$$

Some meters provide a total time-integrated radiance emitted in units of J • cm^{-2} • sr^{-1} over the sampling period, which is the time integral of L_R over the sampling period. Therefore, an alternative expression of the retinal thermal injury TLV is a dose limit (called DL_R in this TLV).

Determine the angular subtense (α) of the source in radians (rad). For circular lamps, α is the lamp diameter divided by the viewing distance. If the lamp is oblong, α is estimated from the mean of the shortest and longest dimension that can be viewed divided by the viewing distance; that is according to Equation 11.

$$\alpha\,[rad] = \frac{(l + w)}{2r} \qquad \textbf{(11)}$$

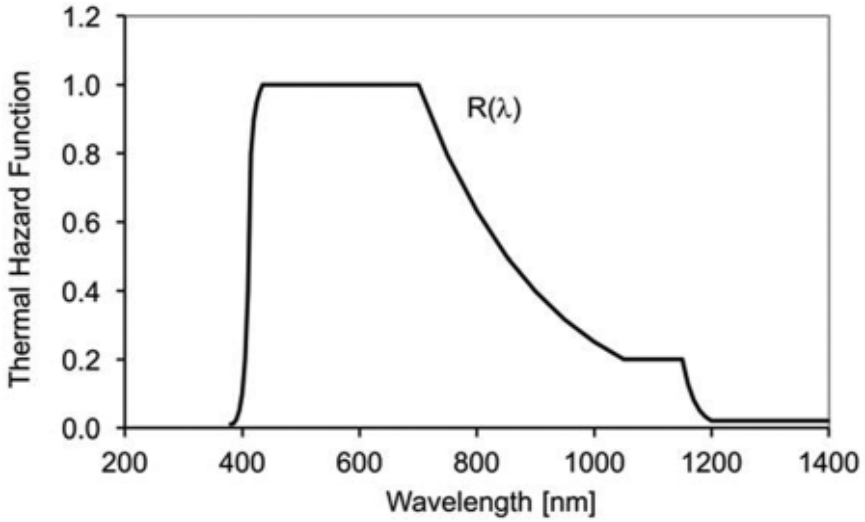


FIGURE 3. Retinal thermal hazard function [R(λ)].

For instance, at a viewing distance r = 100 cm from a 0.8 cm diameter tubular flash lamp of length l = 5 cm, the viewing angle α is 0.029 rad.

Large sources are those with an angular subtense (α) greater than 0.1 rad. For large sources, Equations 12a through 12c define the TLV for protection against retinal thermal injury depending on the exposure duration (t) in seconds [s]. These limits also serve as a useful screening step.

For viewing durations (t) from 1 µs (10^{-6} s) through 0.00063 s, an acceptable exposure is present when Equation 12a is true. For pulse durations less than 1 µs, the TLV is the same as that for 1 µs. Since the retinal thermal hazard TLVs for pulsed sources assume a 7-mm, dark-adapted pupil, this exposure limit may be modified for daylight conditions.

$$L_R\,[W \cdot cm^{-2} \cdot sr^{-1}] \leq 640 \cdot t^{-0.25} \qquad \textbf{(12a)}\blacklozenge$$

OR

$$DL_R\,[J \cdot cm^{-2} \cdot sr^{-1}] \leq 640 \cdot t^{0.75}$$

For viewing durations between 0.63 ms (0.00063 s) and 0.25 s, an acceptable exposure is present when Equation 12b is true.

$$L_R\,[W \cdot cm^{-2} \cdot sr^{-1}] \leq 16 \cdot t^{-0.75} \qquad \textbf{(12b)}\blacklozenge$$

OR

$$DL_R\,[J \cdot cm^{-2} \cdot sr^{-1}] \leq 16 \cdot t^{1/4}$$

For viewing durations greater than 0.25 s, an acceptable exposure is present when Equation 12c is true. This is a rate-limited, rather than dose-limited, threshold.

$$L_R\,[W \cdot cm^{-2} \cdot sr^{-1}] \leq 45 \qquad \textbf{(12c)}\blacklozenge$$

Small sources have an angular subtense (α) less than 0.1 rad, but are limited to no less than 1.7 mrad. For small sources, the retinal thermal injury risk depends on both the exposure duration (t) and α. The interaction is a maximum value for α (α_{max}) as a function of viewing duration (t [s]).

For viewing durations from 1 µs (10^{-6} s) through 0.00063 s, an acceptable exposure is present when Equation 12a above is true. For pulse durations less than 1 µs, the TLV is the same as that for 1 µs. Since the retinal thermal hazard TLVs for pulsed sources assume a 7-mm, dark-adapted pupil, this exposure limit may be modified for daylight conditions.

For viewing durations from 0.00063 to 0.25 s, an acceptable exposure is present when Equation 13a is true.

With $\alpha < \alpha_{max} = 0.2 \cdot t^{0.5}$ rad,

$$L_R\,[W \cdot cm^{-2} \cdot sr^{-1}] \leq 3.2 \cdot \alpha^{-1} \cdot t^{-0.25} \qquad \textbf{(13a)}\blacklozenge$$

OR

$$DL_R\,[J \cdot cm^{-2} \cdot sr^{-1}] \leq 3.2 \cdot \alpha^{-1} \cdot t^{0.75}$$

For viewing durations greater than 0.25 s, an acceptable exposure is present when Equation 13b is true. This is a rate-limited exposure and a dose limit does not apply.

With $\alpha < \alpha_{max} = 0.1$ rad,

$$L_R\,[W \cdot cm^{-2} \cdot sr^{-1}] \leq 4.5 \cdot \alpha^{-1} \qquad \textbf{(13b)}\blacklozenge$$

Note: There may be special individual circumstances where the pupil remains dilated (tonic) and exposures extend beyond 0.25 s. Under these conditions, Equation 13c is the limiting exposure.

With $\alpha < \alpha_{max} = 0.1$ rad,

$$L_R\,[W \cdot cm^{-2} \cdot sr^{-1}] \leq 3.2 \cdot \alpha^{-1} \cdot t^{-0.25} \qquad \textbf{(13c)}\blacklozenge$$

TLV–PA

♦ Equations 9, 12, and 13 are empirical and are not dimensionally correct. To obtain the correct value in the units given on the left side of the equation, α must be in radians and t in seconds. To make the equations dimensionally correct, one would have to insert unity dimensional correction factors in the right-hand numerator in each equation.

* ULTRAVIOLET RADIATION

(Documentation Date – 2023)

These TLVs refer to incoherent ultraviolet (UV) radiation with wavelengths between 180 and 400 nm and represent conditions under which it is believed that nearly all healthy workers may be repeatedly exposed without acute adverse health effects such as erythema and photokeratitis. Some UV sources covered by this TLV are welding and carbon arcs, gas and vapor discharges, fluorescent, incandescent, and germicidal lamps, and solar radiation. Coherent UV radiation from lasers is covered in the TLV for Lasers.

The TLV values apply to continuous sources for exposure durations equal to or greater than 0.1 second. The sources may subtend an angle less than 80 degrees at the detector. For those sources that subtend a greater angle, there is no need to measure an angle greater than 80 degrees.

The values do not apply to UV radiation exposure of photosensitive individuals or of individuals concomitantly exposed to photosensitizing agents (see Note 3). The values at wavelengths greater than 300 nm for the eye do not apply to aphakes (persons who have had the lens of the eye removed in cataract surgery), for which case, see Light and Near-Infrared Radiation TLVs.

The TLVs should be used as guides in the control of exposure to UV sources and should not be regarded as fine lines between safe and dangerous levels. The TLVs in Table 1 apply directly to exposure of the cornea of the eye and provide conservative guidelines for skin exposures. If the eyes are protected, higher levels (Table 2) apply to exposures of the skin in the UV-C (180 to 280 nm) spectral region and below 300 nm.

The TLVs for occupational exposure to UV radiation incident upon the skin or the eye follow. The flow chart in Figure 1 provides a map of the UV TLV.

TLV–PA

Broadband UV Sources (180 to 400 nm) — Corneal Hazard

The first step in evaluating broadband UV sources is to determine the effective irradiance (E_{eff}). To determine E_{eff} for a broadband source weighted against the peak of the spectral effectiveness curve (270 nm), Equation 1 should be used.

$$E_{eff} = \sum_{180}^{400} E_{\lambda} \times S(\lambda) \times \Delta\lambda \qquad \textbf{(1)}$$

where:
- E_{eff} = effective irradiance relative to a monochromatic source at 270 nm [W/cm^2]
- E_{λ} = spectral irradiance at a center wavelength [W/(cm^2 $\times$ nm)]
- $S(\lambda)$ = relative spectral effectiveness at the center wavelength (unitless)
- $\Delta\lambda$ = bandwidth around the center wavelength (nm)

More practically, E_{eff} can be measured directly with a UV radiometer having a built-in spectral response that mimics the relative spectral effectiveness values in Table 1 and Figure 2.

The daily exposure (t_{exp}) based on E_{eff} is dose limited to 0.003 J/cm^2. That is,

$$0.003[J/cm^2] \geq E_{eff}[W/cm^2] \times t_{exp}[s] \quad \textbf{(2)}$$

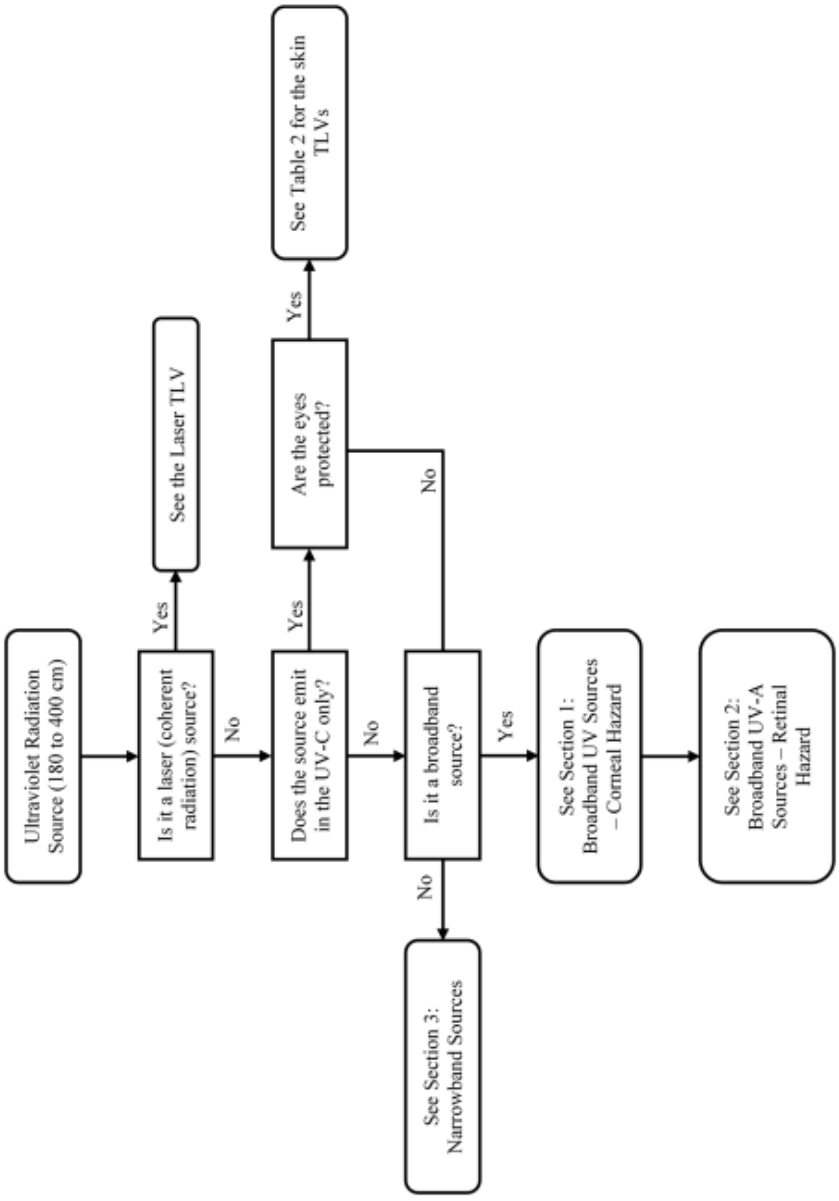


FIGURE 1. Flow chart for UV TLV.

TABLE 1. Ultraviolet Radiation TLV and Relative Spectral Effectiveness

Wavelength[a] (nm)	TLV (J/m^2)[B]	TLV (mJ/cm^2)[b]	Relative Spectral Effectiveness, S(l)
180	16,260	1,626	0.00185
190	16,260	1,626	0.00185
200	16,260	1,626	0.00185
205	16,260	1,626	0.00185
210	10,233	1,023	0.00293
215	4,732	473	0.00634
220	2,188	218	0.0137
225	1,012	101	0.0297
230	468	46.8	0.0641
235	216	21.6	0.139
240	100	10	0.300
245	83	8.3	0.360
250	70	7.0	0.430
254[C]	60	6.0	0.500
255	58	5.8	0.520
260	46	4.6	0.650
265	37	3.7	0.810
270	30	3.0	1.00
275	31	3.1	0.960
280[c]	34	3.4	0.880
285	39	3.9	0.770
290	47	4.7	0.640
295	56	5.6	0.540
297[c]	65	6.5	0.460
300	100	10	0.300
303[c]	250	25	0.120
305	500	50	0.060
308	1,200	120	0.026
310	2,000	200	0.015
313[c]	5,000	500	0.006
315	1.0×10^4	1.0×10^3	0.003
316	1.3×10^4	1.3×10^3	0.0024
317	1.5×10^4	1.5×10^3	0.0020
318	1.9×10^4	1.9×10^3	0.0016
319	2.5×10^4	2.5×10^3	0.0012
320	2.9×10^4	2.9×10^3	0.0010
322	4.5×10^4	4.5×10^3	0.00067
323	5.6×10^4	5.6×10^3	0.00054
325	6.0×10^4	6.0×10^3	0.00050
328	6.8×10^4	6.8×10^3	0.00044
330	7.3×10^4	7.3×10^3	0.00041
333	8.1×10^4	8.1×10^3	0.00037
335	8.8×10^4	8.8×10^3	0.00034
340	1.1×10^5	1.1×10^4	0.00028
345	1.3×10^5	1.3×10^4	0.00024
350	1.5×10^5	1.5×10^4	0.00020

TABLE 1 (cont.). Ultraviolet Radiation TLV and Relative Spectral Effectiveness

Wavelength[a] (nm)	TLV (J/m^2)[b]	TLV (mJ/cm^2)[b]	Relative Spectral Effectiveness, S(l)
355	1.9×10^5	1.9×10^4	0.00016
360	2.3×10^5	2.3×10^4	0.00013
365[c]	2.7×10^5	2.7×10^4	0.00011
370	3.2×10^5	3.2×10^4	0.000093
375	3.9×10^5	3.9×10^4	0.000077
380	4.7×10^5	4.7×10^4	0.000064
385	5.7×10^5	5.7×10^4	0.000053
390	6.8×10^5	6.8×10^4	0.000044
395	8.3×10^5	8.3×10^4	0.000036
400	1.0×10^6	1.0×10^5	0.000030

[a] Wavelengths chosen are representative; other values should be interpolated at intermediate wavelengths.
[b] 1 mJ/cm^2 = 10 J/m^2
[c] Emission lines of a mercury discharge spectrum.

TLV–PA

TABLE 2. Ultraviolet Radiation TLV and Relative Spectral Effectiveness for the Skin (UV-C)

Wavelength[a] (nm)	TLV (J/m^2)[b]	TLV (mJ/cm^2)[b]	Relative Spectral Effectiveness, S'(l) (prime)
180	1.0×10^5	10,000	3.0×10^{-4}
190	1.0×10^5	10,000	3.0×10^{-4}
200	1.0×10^5	10,000	3.0×10^{-4}
205	50,120	5,012	6.0×10^{-4}
210	25,120	2,512	1.19×10^{-3}
215	12,540	1,259	2.38×10^{-3}
220	6,310	631.0	4.75×10^{-3}
225	3,162	316.2	9.49×10^{-3}
230	1,585	158.5	0.0189
235	794	79.4	0.0380
240	400	39.8	0.075
245	200	20.0	0.150
250	100	10	0.30
260	100	10	0.30
270	100	10	0.30
280	100	10	0.30
290	100	10	0.30
300	100	10	0.30

[a] Wavelengths chosen are representative; other values should be interpolated at intermediate wavelengths.
[b] 1 mJ/cm^2 = 10 J/m^2.

Skin Hazard

The TLV (Table 1) values are conservative for skin exposure (see Documentation).

For UV-C (germicidal) wavelengths, if the eyes are protected, higher exposure values (Table 2) can be applied for narrowband sources (e.g., at 254 nm) and for broadband sources a modified spectral weighting function S'(λ) can be applied (Figure 2) in Equation 1 to determine E_{eff}.

Table 3 gives TLV values for the effective irradiance for different daily exposure durations. In general, the maximum exposure time (t_{max}) [s] for a broadband UV source can be determined from Equation 3.

$$t_{\max}[s] = \frac{0.003\,[J/cm^2]}{E_{eff}[W/cm^2]} \quad \textbf{(3)}$$

Broadband UV-A Sources (315 to 400 nm) — Lens and Retinal Hazard

The irradiance, $E_{UV\text{-}A}$ [mW/cm^2], can be measured with an unfiltered meter that is sensitive to UV-A radiation. For daily exposure periods (t_{exp}) less than 1,000 seconds (17 minutes), the exposure is dose limited to 1,000 mJ/cm^2 as described in Equation 4.

$$1{,}000\,[mJ/cm^2] \geq E_{UV\text{–}A}\,[mW/cm^2] \times t_{exp}[s]. \quad \textbf{(4)}$$

For daily exposure periods greater than 1,000 seconds (17 minutes), the exposure is rate limited to 1.0 mW/cm^2 as described in Equation 5.

$$1.0\,[mW/cm^2] \geq E_{UV\text{–}A}\,[mW/cm^2]. \quad \textbf{(5)}$$

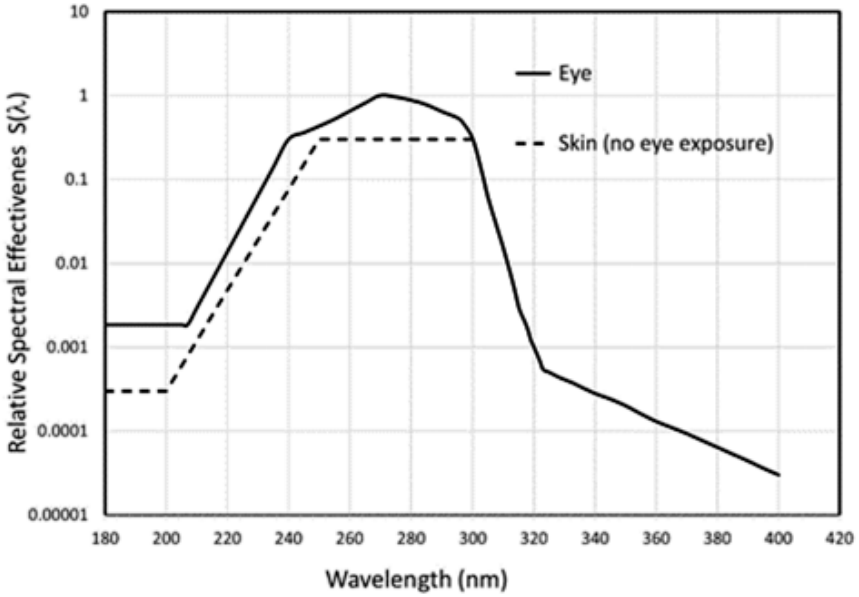


FIGURE 2. Hazard function (relative spectral effectiveness, S(λ)) for UV.

TABLE 3. Exposure Durations for Given Actinic UV Radiation and Effective Irradiances

Duration of Exposure Per Day	Effective Irradiance, E_{eff} (mW/cm^2)
8 hours	0.0001
4 hours	0.0002
2 hours	0.0004
1 hour	0.0008
30 minutes	0.0017
15 minutes	0.0033
10 minutes	0.005
5 minutes	0.01
1 minute	0.05
30 seconds	0.1
10 seconds	0.3
1 second	3
0.5 second	6
0.1 second	30

Narrowband Sources

Narrowband sources are composed of 1 wavelength or a narrow band of wavelengths (e.g., 5 to 10 nm). Locate the center wavelength (λ) in Table 1, and find the TLV_λ as an 8-hour dose limit in J/m^2 or mJ/cm^2. The narrowband TLV is protective for both corneal and retinal exposures.

The dose limit may be adjusted proportionately for work periods of longer or shorter duration. The TLV dose limit of a daily exposure period (t_{exp}) for a narrowband source can be expressed as Equation 6 using the Spectral Sensitivity (S_λ) from Table 1 and unfiltered irradiance (E_λ) [W/m^2 or mW/cm^2].

$$30\ [J/m^2] \geq E_\lambda\ [W/m^2] \times S(\lambda) \times t_{exp}[s] \qquad \textbf{(6a)}$$

$$3.0\ [mJ/cm^2] \geq E_\lambda\ [mW/cm^2] \times S(\lambda) \times t_{exp}[s]. \qquad \textbf{(6b)}$$

The maximum exposure time (t_{max}) [s] for a narrowband source can be determined from Equation 7 using the TLV_λ and the unfiltered irradiance (E_λ) [W/m^2 or mW/cm^2]. (Note: The energy and surface area units must match.)

$$t_{\max}[s] = \frac{TLV_\lambda}{E_\lambda} \qquad \textbf{(7)}$$

Notes:

1. The probability of developing skin cancer depends on a variety of factors such as skin pigmentation, a history of blistering sunburns, and the accumulated UV dose. It also depends on genetic susceptibility and factors such as skin and eye color. Individuals who have a family history of melanoma, or numerous nevi over their body, for example, may be at higher risk of developing malignant melanoma. The risks for developing melanoma and nonmelanoma

cancers may differ from each other and depend on the UV exposure history. Because of their high spectral attenuation by the stratum corneum, UV-C wavelengths pose a much lower risk for delayed effects than UV-B (see Table 2).

2. Outdoor workers in latitudes within 40 degrees of the equator can be exposed outdoors to levels above the TLVs in as little as 5 minutes around noontime during the summer.
3. Exposure to UV radiation concurrently with topical or systemic exposure to various chemicals, including some prescription drugs, can result in skin erythema at sub-TLV exposures. Hypersensitivity should be suspected if workers present skin reactions when exposed to sub-TLV doses or when exposed to levels (generally UV-A) that did not cause a noticeable erythema in the same individual in the past. Among the hundreds of agents that can cause hypersensitivity to UV radiation are certain plants and chemicals such as some antibiotics (e.g., tetracycline and sulphathiazole), some antidepressants (e.g., imipramine and sinequan), as well as some diuretics, cosmetics, antipsychotic drugs, coal tar distillates, some dyes, or lime oil.
4. Ozone is produced in air by sources emitting UV radiation at wavelengths below 242 nm. Refer to the latest version of the Chemical Substances TLV for ozone. This is a particular problem at wavelengths less than 200 nm. Ozone-free UV-C lamps generally have a lamp envelope that heavily attenuate these shorter wavelengths.

LASERS
(Documentation Date – 2020)

TLVs

These TLVs are for exposure to laser radiation under conditions to which it is believed nearly all workers may be repeatedly exposed without adverse health effects. The TLVs should be used as guides in the control of exposures and should not be regarded as fine lines between safe and dangerous levels. They are based on the best available information from experimental studies. In practice, hazards to the eye and skin can be controlled by application of control measures appropriate to the classification of the laser.

Classification of Lasers

Most lasers have a label affixed to them by the manufacturer that describes their hazard class. Normally, it is not necessary to determine laser irradiances or radiant exposures for comparison with the TLVs. The potential for hazardous exposures can be minimized by the application of control measures that are appropriate to the hazard class of the laser. Control measures are applicable to all classes of lasers except for Class 1. Such measures, and other laser safety information, may be found in the ACGIH publication, *A Guide for Control of Laser Hazards*, and the ANSI Z136 series published by the Laser Institute of America.

Limiting Apertures

For comparison with the TLVs in this section, laser beam irradiance or radiant exposure is averaged over the limiting aperture appropriate to the spectral region and exposure duration. If the laser beam diameter is less than that of the limiting aperture, the effective laser beam irradiance or radiant exposure may be calculated by dividing the laser beam power or energy by the area of the limiting aperture. Limiting apertures are listed in Table 1.

TABLE 1. Limiting Apertures Applicable to Laser TLVs

Spectral Region	Duration	Eye	Skin
180-400 nm	100 fs to 0.25 s	1 mm	3.5 mm
180-400 nm	0.25 s to 30 ks	3.5 mm	3.5 mm
400-1,400 nm	10^{-4} ns to 0.25 s	7 mm	3.5 mm
400-1,400 nm	0.25 s to 30 ks	7 mm	3.5 mm
1,400 nm - 0.1 mm	10^{-5} ns to 0.25 s	1 mm	3.5 mm
1,400 nm - 0.1 mm	0.25 s to 30 ks	3.5 mm	3.5 mm
0.1-1.0 mm	10^{-5} ns to 30 ks	11 mm	11 mm

Source Size and Correction Factor C_E

The following considerations apply only at wavelengths in the retinal hazard region, 400–1400 nm (nanometers). Normally, a laser is a small source, which approximates a "point source" and subtends an angle less than α_{min}, which is 1.5 mrad for all values of t. However, any source that subtends an angle, α, greater than α_{min}, and is measured from the viewer's eye, is treated as an "intermediate source" ($\alpha_{min} < \alpha \leq \alpha_{max}$) or a "large, extended source" ($\alpha > \alpha_{max}$). For exposure duration "t", the angle α_{max} is defined as:

α_{max} = 5 mrad for $t \leq 0.625$ ms
$\alpha_{max} = 200 \times t^{0.5}$ mrad for 0.625 ms < t < 0.25 s
α_{max} = 100 mrad for $t \geq 0.25$ s, and
α_{min} = 1.5 mrad

Figure 1 illustrates the time dependence of α_{max}. If the source is oblong, alpha is determined from the arithmetic average of the longest and shortest viewable dimensions.

For intermediate and large sources, the TLVs in Table 2 are modified by a correction factor CE, as detailed in the Notes for Table 2.

Correction Factors A, B, C (C_A, C_B, C_C)

The TLVs for ocular exposures in Table 2 are to be used as given for all wavelength ranges. The TLVs for wavelengths between 700 and 1049 nm are to be increased by the factor CA (to account for reduced absorption of melanin) as given in Figure 2. For certain exposure times at wavelengths between 400 and 600 nm, a correction factor CB (to account for reduced photochemical sensitivity for retinal injury) is applied. The correction factor CC is applied from 1,150 to 1,400 nm to account for pre-retinal absorption of the ocular media.

The TLVs for skin exposure are given in Table 4. The TLVs are to be increased by a factor CA, as shown in Figure 2, for wavelengths between 700 nm and 1,400 nm. To aid in the determination for exposure durations requiring calculations of fractional powers, Figures 3a, 3b, 4a, and 4b may be used.

Repetitively Pulsed Exposures

Scanned, continuous-wave (CW) lasers or repetitively pulsed lasers can both produce repetitively pulsed exposure conditions. The TLV for intrabeam viewing, which is applicable to wavelengths between 400 and 1,400 nm and a single-pulse exposure (of exposure duration $t > t_{min}$), is modified in this instance by a correction factor determined by the number of pulses in the exposure. First, calculate the number of pulses (n) in an expected exposure situation; this is the pulse repetition frequency (PRF in Hz) multiplied by the duration of the exposure. Normally, realistic exposures may range from 0.25 s for a bright visible source to 10 s for an infrared source. The corrected TLV on a per-pulse basis is:

$$TLV = (C_P)(\text{TLV for Single-pulse}) \quad \textbf{(1)}$$

where $C_P = 1.0$ for $t < t_{min}$ (i.e. 5 μs for 400-1,050 nm and 13 μs for 1,050-1,400 nm) and for $t > t_{min}$, $C_P = 1.0$ for $\alpha < 5.0$ milliradians, which applies to all cases of intrabeam viewing. However, for larger, intermediate extended sources where $\alpha > 5$ mrad, $C_P = n^{-0.25}$ for the following numbers of pulses: for $n < 40$ pulses, otherwise, $C_P = 0.4$ whenever $\alpha < \alpha_{max}$; for $\alpha_{max} \leq \alpha < 0.1$ radians and $n < 625$, $C_P = n^{-0.25}$ and for greater n, $C_P = 0.2$. For $\alpha > 0.1$ radian, $C_P = 1.0$. This approach applies only to thermal-injury conditions, i.e. all exposures at wavelengths > 700 nm and for many exposures at shorter wavelengths. For wavelengths ≤ 700 nm, the corrected TLV from Equation 1 applies if the average irradiance does not exceed the TLV for continuous exposure. The average irradiance (i.e. the total accumulated exposure for *nt* s) should not exceed the radiant exposure given in Table 2 for exposure durations of 10 s to T_1. Some thermal additivity can occur for larger image sizes, and for pulse repetition frequencies (PRFs) between 150 Hz and 250 Hz where $\alpha > 5$ mrad and the pulse duration is between 1 ms and 100 ms, the single-pulse TLV applied should be reduced by a further correction factor, $C_P = 0.5$.

For ultraviolet wavelengths, the accumulated exposure of repetitive exposures is added up to the total duration of exposure (up to a maximal duration of 3×10^4 s). For repetitive pulse trains, the total accumulated radiant exposure for nt s of a group of pulses should not exceed the exposure given in Table 2 for exposure durations of 10 s to 3×10^4 s with continuous exposures.

It is recommended that the user of the TLVs for laser radiation consult *A Guide for Control of Laser Hazards*, 4th Edition, 1990, published by ACGIH, for additional information on control measures.

TABLE 2. TLVs for Direct Ocular Exposures (Intrabeam "Point-Source" Viewing from a Laser Beam

Spectral Region	Wavelength, nm	Exposure (t), seconds	TLV
All UV	180-400	10^{-13} to 10^{-11}	0.3 mJ/cm^2
	180-400	10^{-11} to 10^{-9}	1 mJ/cm^2
UVC[a]	180-260	10^{-9} to 3×10^4	$3 \times 10^{0.033(260\ nm-\lambda)}$ mJ/cm^2
	260-280[b]	10^{-9} to 3×10^4	3 mJ/cm^2
UVB[a]	280-302	"	3 mJ/cm^2
	303	"	4 mJ/cm^2
	304	"	6 mJ/cm^2
	305	"	10 mJ/cm^2
	306	"	16 mJ/cm^2
	307	"	25 mJ/cm^2
	308	"	40 mJ/cm^2
	309	"	63 mJ/cm^2
	310	"	100 mJ/cm^2
	311	"	160 mJ/cm^2
	312	"	250 mJ/cm^2
	313	"	400 mJ/cm^2
	314	"	630 mJ/cm^2
UVA	315-400	10^{-9} to 10	$0.56t^{¼}$ J/cm^2
	315-400	10 to 10^3	1.0 J/cm^2
	315-400	10^3 to 3×10^4	1.0 mW/cm^2
Light	400-700	10^{-13} to 10^{-11}	1×10^{-7} J/cm^2
	400-700	10^{11} to 5×10^{-6}	2×10^{-7} J/cm^2
	400-700	5×10^{-6} to 10	$1.8\ t^{¾} \times 10^{-3}$ J/cm^2
	400-450	10 to 100	10 mJ/cm^2
	450-500	10 to T_1	1 mW/cm^2
	450-500	T_1 to 100	10 C_B mJ/cm^2
	400-500	100 to 3×10^4	0.1 C_B mW/cm^2
	500-700	10 to 3×10^4	1.0 C_B mW/cm^2

TABLE 2 (contd.). TLVs for Direct Ocular Exposures (Intrabeam "Point-Source" Viewing from a Laser Beam

Spectral Region	Wavelength, nm	Exposure (t), seconds	TLV
IRA	700-1,050	10^{-13} to 10^{-11}	1.0×10^{-7} J/cm^2
	700-1,050	10^{-11} to 5×10^{-6}	$2.0\ C_A \times 10^{-7}$ J/cm^2
	700-1,050	5×10^{-6} to 10	$1.8\ C_A \times t^{0.75} \times 10^{-3}$ J/cm^2
	700-1,050	10 to 3×10^4	$C_A \times 10^{-3}$ W/cm^2
	1,050-1,400	10^{-13} to 10^{-11}	$C_C \times 10^{-7}$ J/cm^2
	1,050-1,400	10^{-11} to 1.3×10^{-5}	$2\ C_C \times 10^{-6}$ J/cm^2
	1,050-1,400	1.3×10^{-5} to 10	$9\ 0\ C_C\ t^{0.75} \times 10^{-3}$ J/cm^2 TLV-C: 35 J/cm^2
	1,050-1,400	10 to 3×10^4	$5.0\ C_C \times 10^{-3}$ W/cm^2 TLV-C: 3.5 W/cm^2
IRB & IRC	1.401-1.5 µm	10^{-13} to 10^{-3}	0.3 J/cm^2
	1.401-1.5 µm	10^{-3} to 4.0	$0.56\ t^{0.25} + 0.2$ J/cm^2
	1.401-1.5 µm	4.0 to 10	1.0 J/cm^2
	1.501-1.8 µm	10^{-13} to 10	1.0 J/cm^2
	1.801-2.6 µm	10^{-13} to 10^{-3}	0.1 J/cm^2
	1.801-2.6 µm	10^{-3} to 10	$0.56\ t^{1/4}$ J/cm^2
	2.601-10^3 µm	10^{-13} to 10^{-7}	10 mJ/cm^2
	2.601-10^3 µm	10^{-7} to 10	$0.56\ t^{1/4}$ J/cm^2
	1.400-10^3 µm	10 to 3×10^4	100 mW/cm^2

[a] For all UVC and UVB wavelengths, TLV-C: $0.56\ t^{1/4}$ J/cm^2 for t ≤ 2 s.

[b] Ozone (O_3) is produced in air by sources emitting ultraviolet (UV) radiation at wavelengths below 250 nm. Refer to Chemical Substances TLV for ozone.

Notes for Table 2:

C_A = Fig. 2; C_B = 1 for λ = 400 to ≤450 nm; $C_B = 10^{0.02(\lambda-450)}$ for λ = 450-600 nm; C_C= 1.0 for wavelengths ≤1,150 nm; $C_C = 10^{[0.018(\lambda-1,150)]}$ for wavelengths >1,150 nm and <1,200 nm; $C_C = 8.0 + 10^{[0.04(\lambda-1,250)]}$ from 1,200-1,400 nm.

T_1 = 10 s for λ = 400-450 nm; $T_1 = 10 \times 10^{[0.02(\lambda-450)]}$ for λ = 450-500 run; and T_1 = 10 s for λ = 500-700.

TABLE 2 (contd.). TLVs for Direct Ocular Exposures (Intrabeam "Point-Source" Viewing from a Laser Beam

For intermediate or large sources (e.g., laser diode arrays) at wavelengths between 400 and 1,400 nm, the intrabeam viewing TLVs can be increased by correction factor C_E (use Table 3) provided that the angular subtense α of the source (measured at the viewer's eye) is greater than α_{min}. C_E depends on α as follows:

Angular Subtense	Source Size Designation	Correction Factor C_E
$\alpha \leq \alpha_{min}$	Small	$C_E = 1$
$\alpha_{min} < \alpha \leq \alpha_{max}$	Intermediate	$C_E = \alpha/\alpha_{min}$
$\alpha = \alpha_{max}$	Large	$CE = \alpha_{max} / \alpha_{min} = 3.33$ for $t \leq 0.625$ ms
		$CE = 133\ t^{½}$ for 0.625 ms $< t < 0.25$ s
		$CE = 66.7$ for $t \geq 0.25$ s

The angle referred to as α_{max} corresponds to the angular source size where the TL Vs may be expressed as a constant time-integrated radiance or radiance dose (J/(cm^2 sr) or radiance (W/(cm^2 sr) and the TLVs for $\alpha > \alpha_{max}$ can be written in terms of integrated radiance $L_{TLV} \times t$ or radiance L_{TLV}.

$L_{TLV} = (1.7 \times 10^5) \times (TLV_{pt\ source})$ J/(cm^2 sr) for $t < 0.625$ µs for $400 < \lambda < 700$ nm
$L_{TLV} = 7.6\ t^{¼}$ J/(cm^2 sr) for 0.625 ms $< t < 0.25$ s for $400 < \lambda < 700$ nm
$L_{TLV} = 4.8$ W/(cm^2 sr) for $t > 100$ s for $400 < \lambda < 700$ nm

Figure 5 illustrates these TLVs for large sources expressed in terms of radiance. The measurement aperture should be placed at a distance of ≥100 mm from the source. For large area irradiation, the reduced TLV for skin exposure applies as noted in the footnote to "IRB & C," Table 4.

TABLE 3. TLVs for Extended-Source Laser Viewing Conditions

Spectral Region	Wavelength, nm	Exposure (t), seconds	TLV
Light	400-700	10^{-13} to 10^{-11}	$C_E \times 10^{-7}$ J/cm^2
	400-700	10^{-11} to 5×10^{-6}	$2\ C_E \times 10^{-7}$ J/cm^2
	400-700	5×10^{-6} to 10	$1.8\ C_E \times t^{-0.75} \times 10^{-3}$ J/cm^2
	400-700	18×10^{-6} to 0.7	$1.8\ C_E \times t^{0.75} \times 10^{-3}$ J/cm^2
Dual limits for 400-600 nm visible laser exposure for t > 0.7 s			
Photochemical			
For α ≤ 11 mrad, the MPE is expressed as irradiance and radiant exposure*			
	400-600	0.7 to 100	$C_B \times 10^{-2}$ J/cm^2
	400-600	100 to 3×10^4	$C_B \times 10^{-4}$ W/cm^2
For α > 11 mrad, the MPE is expressed as radiance and integrated radiance*			
	400-600	0.7 to 1×10^4	$100\ C_B$ J/(cm^2 sr)
	400-600	1×10^4 to 3×10^4	$C_B \times 10^{-2}$ W/(cm^2 sr)
Thermal			
	400-700	0.7 to T_2	$1.8\ C_E\ t^{0.75} \times 10^{-3}$ J/cm^2
	400-700	T_2 to 3×10^4	$1.8\ C_E\ T_2^{-0.25} \times 10^{-3}$ W/cm^2
IRA	700-1,050	10^{-13} to 10^{-11}	$C_E \times 10^{-7}$ J/cm^2
	700-1,050	10^{-11} to 5×10^{-6}	$5\ C_A\ C_E \times 10^{-7}$ J/cm^2
	700-1,050	5×10^{-6} to T_2	$1.8\ C_A\ C_E\ t^{0.75} \times 10^{-3}$ J/cm^2
	700-1,050	T_2 to 3×10^4	$1.8\ C_A\ CE\ T_2^{-0.25} \times 10^{-3}$ W/cm^2
	1,050-1,400	10^{-13} to 10^{-11}	$C_C\ C_E \times 10^{-7}$ J/cm^2
	1,050-1,400	10^{-11} to 1.3×10^{-5}	$2\ C_C\ C_E \times 10^{-6}$ J/cm^2
	1,050-1,400	13×10^{-6} to T_2	$9.0\ C_C\ C_E\ t^{0.75} \times$ 10-3 J/cm^2; TLV-C: 35 J/cm^2
	1,050-1,400	T_2 to 3×10^4	$9.0\ C_C\ C_E\ T_2^{-0.75} \times 10^{-3}$ W/cm^2; TLV-C: 3.5 W/cm^2

TABLE 3 (contd.). TLVs for Extended-Source Laser Viewing Conditions

*For sources subtending an angle greater than 11 mrad, the limit may also be expressed as an integrated radiance.

L_p = 100 C_B J/(cm^2 sr) for 0.7 s ≤ t ≤ 10^4 s and L_e= CB × 10-2 W/(cm^2 sr) for t ≥ 10_4 s as measured through a limiting cone angle γ.

These correspond to values of J/cm^2 for 10 s·≤ t < 100 s and W/cm^2 for t ≥ 100 s as measured through a limiting cone angle γ.

γ = 11 mrad for 0.7 s ≤ t < 100 s

$\gamma = 1.1 \times t^{0.5}$ mrad for 100 s ≤ t < 10^4 s

γ = 110 mrad for 10^4 s ≤ t < 3×10^4 s

$T_2 = 10 \times 10^{(\alpha\text{-}1\ 5)/98.5}$ for α expressed in mrad for α = 400-1,400 nm.

For exposure duration "t," the angle α_{max} is defined as:

α_{max} = 5 mrad for t ≤ 0.625 ms

$\alpha_{max} = 200\ t^{0.5}$ mrad for 0.625 ms < t < 0.25 s, and

α_{max} = 100 mrad for t ≥ 0.25 s

L_p = 100 C_B J/(cm^2 sr) for 0.7 s ≤ t < 10^4 s and $L_e = C_B \times$ to·10^{-2} W/(cm^2 sr) for t ≥ 10^4 as measured through a limiting cone angle γ.

TLV–PA

Notes for Tables 2 and 3:

NTE: To protect the cornea and lens, the TLVs for wavelengths between 400 nm and 1.4 µm in Table 3 should not exceed:

Wavelength, nm nm	Exposure, (t) Seconds	NTE (Second of Dual Limits)†
400-1,400	10^{-13} to 10^{-7}	6 $C_A \times 10^{-2}$ J/cm^2
400-1,400	10^{-7} to 10	3.3 C_A t¼ J/cm^2
400-1,400	10 to 3×10^4	0.6 C_A W/cm^2

† These dual limits will rarely apply except for exposures of very large angular sub tense α, at least for wavelengths <1,200 nm.

TABLE 4. TLVs for Skin Exposure from a Laser Beam

Spectral Region	Wavelength	Exposure, (t) Seconds	TLV
Uv[a]	180-400 nm	10^{-13} to 3×10^{4}	Same as Table 2
Light & IRA	400-1,400 nm	10^{-13} to 10^{-11}	$2\ C_A \times 10^{-3}$ J/cm^2
	”	10^{-11} to 10^{-9}	$6\ C_A \times 10^{-3}$ J/cm^2
	”	10^{-9} to 10^{-7}	$2\ C_A \times 10^{-2}$ J/cm^2
	”	10^{-7} to 10	$1.1\ C_A\ ^4\sqrt{t}$ J/cm^2
	”	10 to 3×10^{4}	$0.2\ C_A$ W/cm^2
IRB & IRC[b]	1.401-10^3 μm	10-13 to 3×10^{4}	Same as Table 2

[a] Ozone (O_3) is produced in air by sources emitting ultraviolet (UV) radiation at wavelengths below 250 nm. Refer to Chemical Substances TLV for ozone.

C_A= 1.0 for Λ = 400-700 nm; see Figure 2 for Λ = 700-1400 nm

[b] At wavelengths greater than 1,400 nm, for beam cross-sectional areas exceeding 100 cm^2, the TLV for exposure durations exceeding 10 seconds is:

TLV = (10,000/A_s) mW/cm^2

Where A^s is the irradiated skin area for 100-1,000 cm^2, and the TLV is 10 mW/cm^2 for irradiated skin areas exceeding 1,000 cm^2 and is 100 mW/cm^2 for irradiated skin areas less than 100 cm^2.

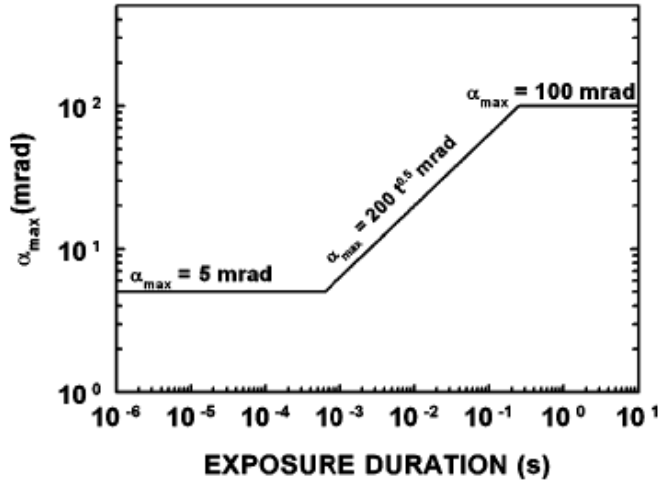


FIGURE 1. Variation of α_{max} with exposure duration.

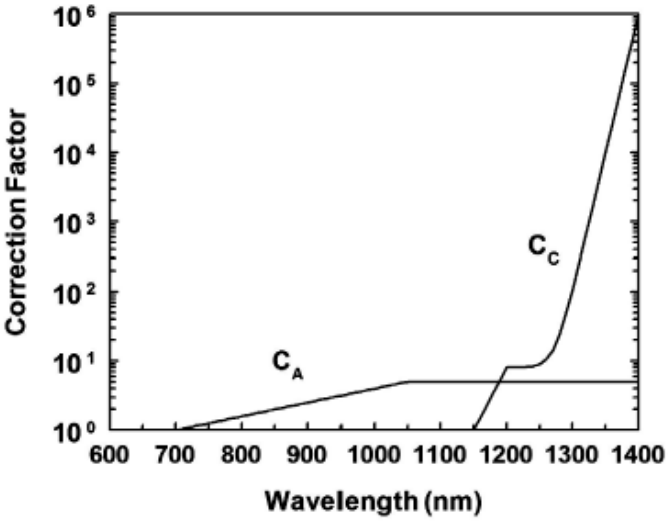


FIGURE 2. TLV correction factors for λ = 700-1,400 nm*
*For λ = 700-1,049 nm, $C_A = 10^{[0.002(\lambda - 700)]}$; for λ = 1,050-1,400 nm, C_A = 5; for $\lambda \leq$ 1,150 nm, C_C = 1; for λ = 1,150-1,200 nm, $C_C = 10^{[0.018(\lambda - 1150)]}$; and for λ = 1,200-1,399 nm, $C_C = 8 + 10^{[0.04(\lambda - 1,250)]}$.

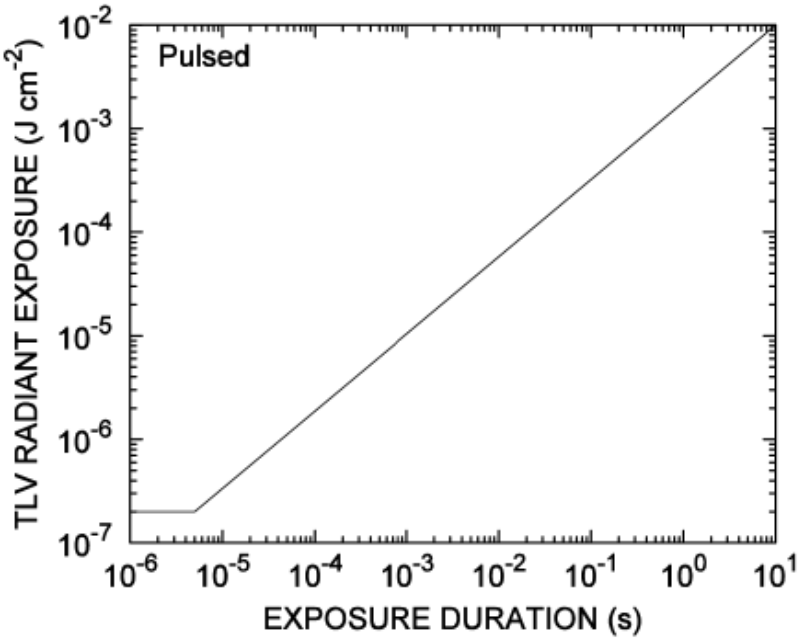


FIGURE 3a. TLV for intrabeam viewing of laser beam (400-700 nm).

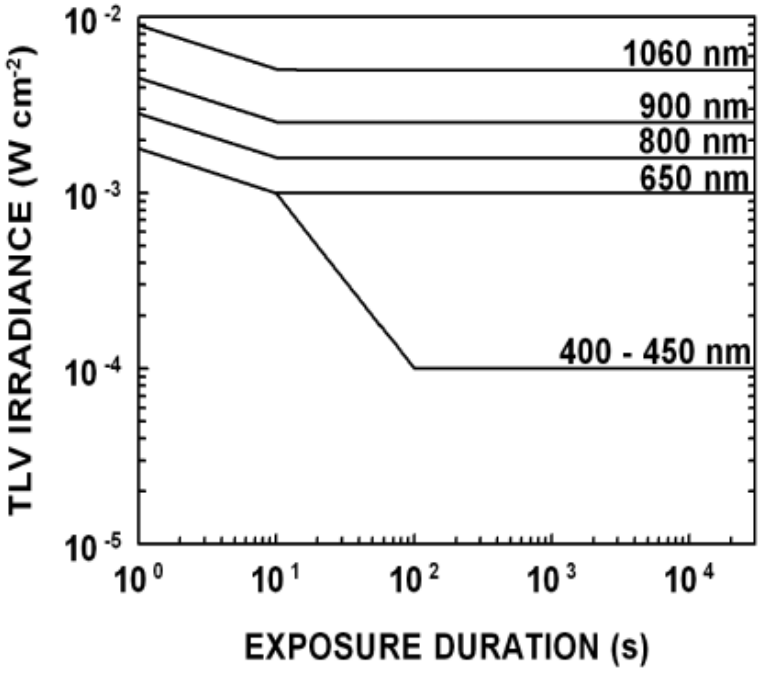


FIGURE 3b. TLV for intrabeam (direct) viewing of CW laser beam (400-1,400 nm).

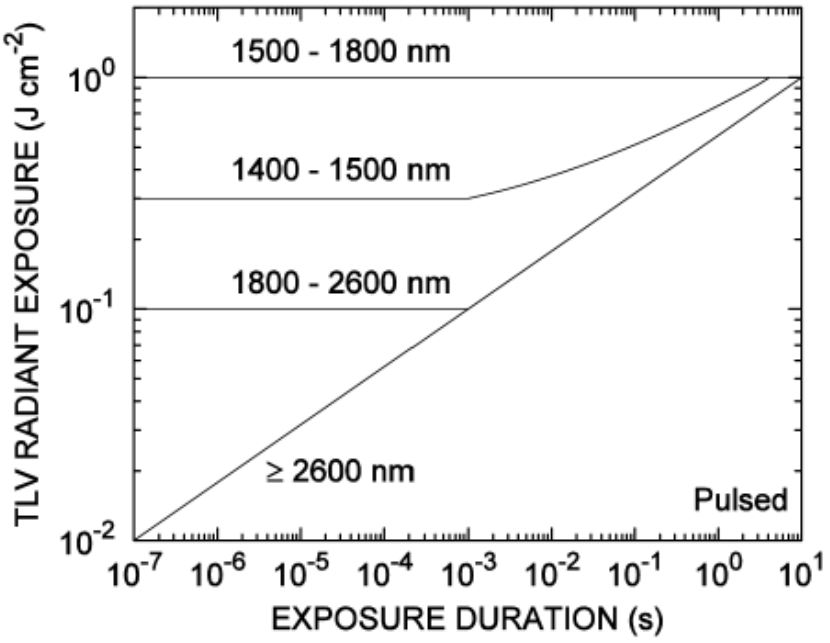


FIGURE 4a. TLV for laser exposure of skin and eyes for far-infrared radiation (wavelengths greater than 1,400 nm).

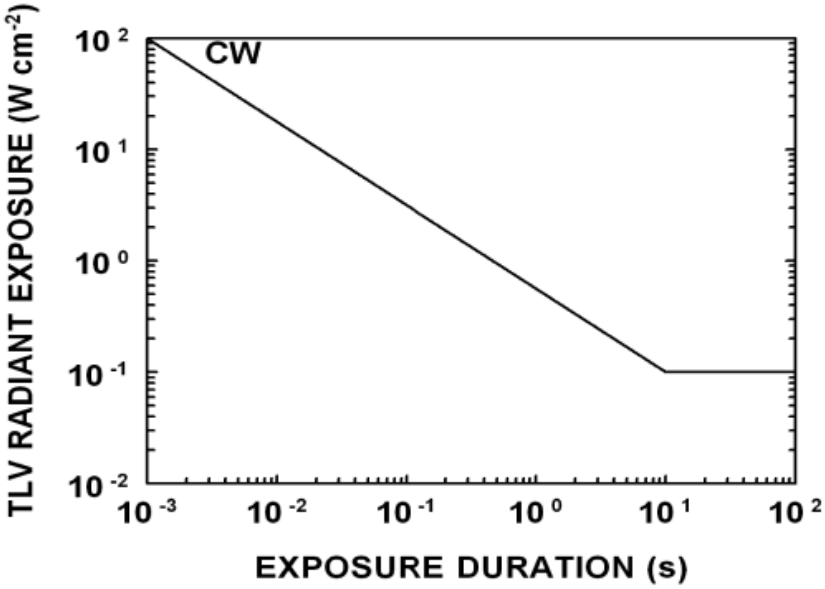


FIGURE 4b. TLV for CW laser exposure of skin and eyes for far-infrared radiation (wavelengths greater than 1.4 µm).

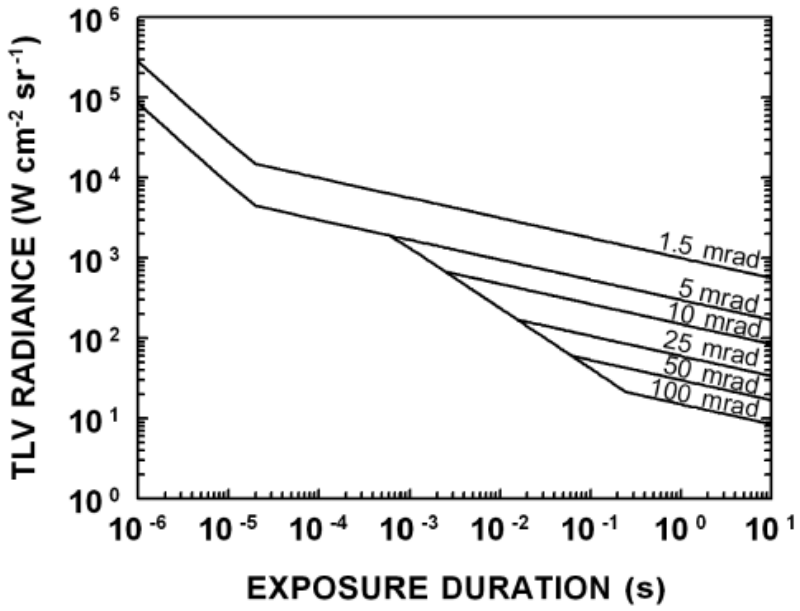


FIGURE 5. TLVs in terms of radiance for exposures to extended-source lasers in the wavelength range of 400 to 700 nm.

* IONIZING RADIATION
(Documentation Date – 2021)

ACGIH has adopted as a TLV for occupational exposure to ionizing radiation the guidelines of the National Council on Radiation Protection and Measurements[1] and certain guidance from the International Council on Radiation Protection (ICRP).[2] Ionizing radiation includes particulate radiation (α particles and β particles emitted from radioactive materials, and neutrons, protons and heavier charged particles produced in nuclear reactors and accelerators) and electromagnetic radiation (gamma rays emitted from radioactive materials and X-rays from electron accelerators and X-ray machines) with energy greater than 12.4 electron volts (eV) corresponding to wavelengths less than approximately 100 nanometers (nm).

The guiding principles of ionizing radiation protection are:

- ***Justification:*** Actions to add, increase, reduce or remove a source of exposure to humans require justification (i.e., the action does more good than harm). All factors, both radiological and nonradiological, and particularly the economic, societal, psychological and environmental implications (including to nonhuman biota), should be considered in that justification.[1]
- ***Optimization of Protection:*** The likelihood of incurring exposures, the number of individuals exposed, and the magnitude of the dose to an individual should be kept as low as reasonably achievable, taking into account societal, economic and environmental factors (i.e., ALARA principle). More generally, optimization of protection is satisfied when the expenditure of further resources would be unwarranted by improvement in health and safety (both radiological and nonradiological). The level of protection should be the best under the prevailing circumstances, maximizing the margin of benefit over harm.[1]
- ***Dose Limit:*** The dose limit is the numeric protection criterion recommended by NCRP for management of dose to an individual for a given exposure situation that establishes a starting point, below which the options for optimization of protection should be evaluated for that particular exposure situation. If the initial circumstances for a particular exposure situation are such that the dose limit is exceeded, the first objective is to meet that dose limit, then optimization of protection should be applied. Dose limits do not apply to medical exposure of patients or exposure to ubiquitous background radiation (with the exception of elevated levels of radon in dwellings and the workplace, and to solar and cosmic radiation in certain occupational circumstances).[1]

There is no identified dose threshold for those radiation effects classified as stochastic. The dose limits are selected so that the risk of inducing a fatal cancer during the lifetime of the exposed individual is less than 10^{-3} per year.*

* This level of risk is based on the NCRP[1] and ICRP[2] estimate of a 5% lifetime risk of fatal cancer for a total exposure of 1 Sv distributed over occupational exposures of 20 mSv annual doses averaged over 5 years.

There is also some question whether radiation-induced cataract formation has a low-dose threshold. Overall, the emphasis in radiation protection is on optimization of protection.

TLV guidelines are the dose limits shown in Table 1. Application of the ALARA principle is achieved through optimization of protection, which is to be applied in all exposure situations and is the methodology by which doses are managed in practice to be well below the dose limit.[1]

TABLE 1. Dose Limits for Management of Exposures to an Individual[a] (abstracted from NCRP[1])

Exposure Situation	Dose Limit (mSv)[b]
Effective Dose: *Stochastic Effects*	
Annual (≥18 years of age)	Should not exceed 50 mSv[c]
Cumulative (≥18 years of age)	Should not exceed 10 mSv times current age in years[d]
Minors under 18 years of age	Should not exceed 1 mSv per year
Embryo-fetus of pregnant worker following declaration of pregnacy	Should not exceed 0.5 mSv per month (equivalent dose in the embryo-fetus
Radon and radon daughters	Include in annual dose if activity concen tration in air >300 Bq m^{-3} after application of radon mitigation measures
Absorbed Dose[f]: *Tissue Reactions*	
a) Lens of the eye	Should not exceed 50 mGy per year in the lens of the eye
b) skin, hands, and feet	Should not exceed 500 mGy in skin or extremities per year, averaged over the most highly exposed 10 cm^2 of skin

mSv = millisievert

[a] Doses for stochastic effects are the effective doses from combined external and internal sources except from ubiquitous background radiation (with the exception of elevated levels of radon in the workplace, and solar and cosmic radiation in certain occupational circumstances). Doses for tissue reactions are the absorbed doses in the specified tissues. Definitions of absorbed dose and effective dose are given below.

[b] In all cases, the phrase “should not exceed” conveys that the first objective for management

of dose to an individual is to meet the applicable numeric protection criterion, and then to apply optimization of protection. The phrase "should not exceed" is not intended to mean that the value is suitable as a regulatory dose limit. NCRP recognizes: (1) that there may be exposure situations in which initial doses to individuals are greater than the applicable numeric protection criterion, and (2) that the values are not a boundary between safe and unsafe exposures.[1]

[c] 10 mSv = 1 rem.

[d] NCRP acknowledges that, in practice, the costs and logistics of tracking doses may make cumulative lifetime recording difficult. [1]

[e] Situations in which a worker who has declared her pregnancy may be exposed to radioiodine should be minimized or avoided if possible because of the risk of congenital hypothyroidism (NCRP, 2018).

[f] If it is necessary to apply this recommendation to high-LET radiation, NCRP recommends that the absorbed dose in the skin or extremities or the lens of the eye should be multiplied by the biological effectiveness of the high-LET radiation that is appropriate for the tissue reaction.[1]

References

1. National Council on Radiation Protection and Measurements (NCRP). NCRP report no. 180: Management of exposure to ionizing radiation—radiation protection guidance for the United States. Bethesda (MD): NCRP. 2018.
2. International Commission on Radiological Protection (ICRP). The 2007 Recommendations of the International Commission on Radiological Protection, ICRP Publication 103. Ann ICRP. 2007; 37(2-4).

ERGONOMICS

Ergonomics is the term applied to the field that studies and designs the human–machine interface to prevent illness and injury and to improve work performance. It attempts to ensure that jobs and work tasks are designed to be compatible with the capabilities of the workers. ACGIH recognizes that some physical agents play an important role in ergonomics. Force and acceleration are addressed, in part, in the Hand–Arm Vibration (HAV) and Whole-Body Vibration (WBV) TLVs. Thermal factors are addressed, in part, in the TLVs for Thermal Stress. Force is also an important causal agent in injuries from lifting. Other important ergonomic considerations include work duration, repetition, contact stresses, postures, and psychosocial issues.

STATEMENT ON WORK-RELATED MUSCULOSKELETAL DISORDERS

(Documentation Date – 2005)

ACGIH recognizes work-related musculoskeletal disorders (MSDs) as an important occupational health problem that can be managed using an ergonomics health and safety program. The term musculoskeletal disorders refers to chronic muscle, tendon, and nerve disorders caused by repetitive exertions, rapid motions, high forces, contact stresses, extreme postures, vibration, and/or low temperatures. Other commonly used terms for work-related musculoskeletal disorders include cumulative trauma disorders (CTDs), repetitive motion illnesses (RMIs), and repetitive strain injuries (RSIs).

Some of these disorders fit established diagnostic criteria such as carpal tunnel syndrome or tendinitis. Other musculoskeletal disorders may be manifested by nonspecific pain. Some transient discomfort is a normal consequence of work and is unavoidable, but discomfort that persists from day to day or interferes with activities of work or daily living should not be considered an acceptable outcome of work.

Control Strategies

The incidence and severity of MSDs are best controlled by an integrated ergonomics program. Major program elements include:

- Recognition of the problem,
- Evaluation of suspected jobs for possible risk factors,
- Identification and evaluation of causative factors,
- Involvement of workers as fully informed active participants, and
- Appropriate health care for workers who have developed musculoskeletal disorders.

General programmatic controls should be implemented when risk of MSDs is recognized. These include:

- Education of workers, supervisors, engineers, and managers;
- Early reporting of symptoms by workers; and
- Ongoing surveillance and evaluation of injury, health and medical data.

Job-specific controls are directed to individual jobs associated with MSDs. These include engineering controls and administrative controls. Personal protection may be appropriate under some limited circumstances.

Among engineering controls to eliminate or reduce risk factors from the job, the following may be considered:

- Using work methods engineering, e.g., time study, motion analysis, to eliminate unnecessary motions and exertions.
- Using mechanical assists to eliminate or reduce exertions required to hold tools and work objects.
- Selecting or designing tools that reduce force requirements, reduce holding time, and improve postures.
- Providing user-adjustable workstations that reduce reaching and improve postures.
- Implementing quality control and maintenance programs that reduce unnecessary forces and exertions, especially associated with nonvalue-added work.

Administrative controls reduce risk through reduction of exposure time and sharing the exposure among a larger group of workers. Examples include:

- Implementing work standards that permit workers to pause or stretch as necessary but at least once per hour.
- Re-allocating work assignments (e.g., using worker rotation or work enlargement) so that a worker does not spend an entire workshift performing high-demand tasks.

Due to the complex nature of musculoskeletal disorders, there is no "one size fits all" approach to reducing the incidence and severity of cases. The following principles apply to selecting actions:

- Appropriate engineering and administrative controls will vary from industry to industry and company to company.
- Informed professional judgment is required to select the appropriate control measures.
- Work-related MSDs typically require periods of weeks to months for recovery. Control measures should be evaluated accordingly to determine their effectiveness.

Nonoccupational Factors

It is not possible to eliminate all musculoskeletal disorders via engineering and administrative controls. There are individual and organizational factors that may influence the likelihood that an individual will experience musculoskeletal disorders. Some cases may be associated with nonoccupational factors such as:

- Rheumatoid arthritis
- Endocrinological disorders
- Acute trauma
- Obesity
- Pregnancy
- Age
- Gender

- Level of physical condition
- Previous injuries
- Diabetes
- Recreational/leisure activities

The recommended TLV may not provide protection for people with these conditions and/or exposures. Engineering and administrative actions can help eliminate ergonomic barriers for persons with predisposing conditions and thus help to minimize disability.

Chronology of the Statement

1995: *Proposed* "Lifting Statement"
1996: Adopted with name change to "Musculoskeletal Statement"
2000: Editorial changes
2004: Editorial changes

HAND ACTIVITY

(Documentation Date – 2018)

Although work-related musculoskeletal disorders can occur in a number of body regions (including the shoulders, neck, low back, and lower extremities), the focus of this TLV is on the hand, wrist, and forearm.

The TLV shown in Figure 1 is based on epidemiological, psychophysical, and biomechanical studies and is intended for jobs performed from 4 to 8 hours per day. The TLV specifically considers average Hand Activity Level (HAL) and Normalized Peak Force (NPF) to represent conditions to which it is believed nearly all workers may be repeatedly exposed without adverse health effects.

HAL is based on the frequency of hand exertions and the duty cycle (distribution of work and recovery periods). HAL can be determined by trained observers based on exertion frequency, rest pauses and speed of motion using the rating scale shown in Figure 2. Only hand exertions greater than 10% of posture specific strength should be considered. HAL can also be calculated based on empirical studies of expert ratings, hand exertion frequency and duty cycle (exertion time/(exertion + rest time) $\times$ 100%). HAL can be calculated as:

$$\mathrm{HAL} = 6.56 \ln D \left[\frac{F^{1.31}}{1 + 3.18 F^{1.31}} \right] \quad \textbf{(1)}$$

(D = duty cycle [%] and F = hand exertion frequency [exertions/s]) or estimated from Table 1. Calculated HAL values should be rounded to the nearest whole number.

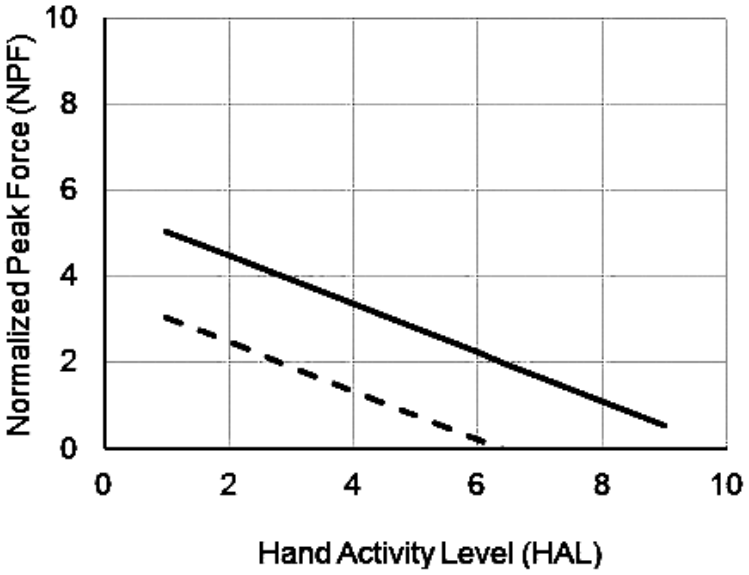


FIGURE 1. The hand activity TLV for reduction of work-related musculoskeletal disorders based on hand activity level (HAL) and normalized peak hand force.

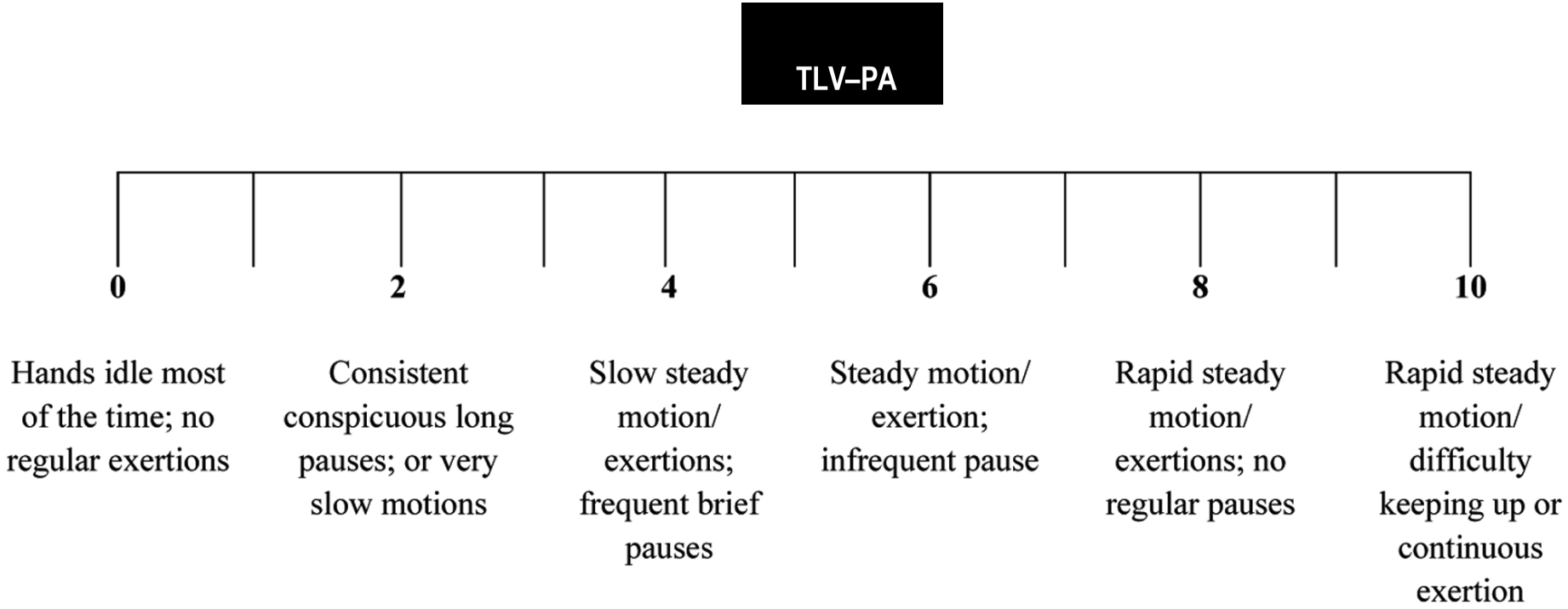


FIGURE 2. Hand activity level (HAL) (0–10) can be rated using the above guidelines.

TABLE 1. Hand Activity Level (HAL) (0-10) is Related to Hand Exertion Frequency and Duty Cycle (percent of work cycle where hand force is greater than 10% of posture specific strength)

		Duty Cycle (%)				
Frequency (exertions/s)	**Period (s/exertion)**	**0-20**	**20-40**	**40-60-**	**60-80**	**80-100**
0.125	8.0	1	1	—	—	—
0.25	4.0	2	2	3	—	—
0.5	2.0	3	4	5	5	5
1.0	1.0	4	5	6	7	7
2.0	0.5	—	6	7	8	8

Notes:

1. Round HAL values to the nearest whole number.
2. Use Figure 2 to obtain HAL values outside those listed in the table.

Peak hand force (PF) is a typically high value of hand force, generally taken to be the 90th percentile force exerted by the hand over the task period. Peak hand force is normalized to a scale of 0 to 10, which corresponds to 0% to 100% of the posture-specific strength for the applicable population (males, females, young, old, office workers, factory workers, etc.):

Normalized Peak Force (NPF) = (Peak force/Posture specific referent strength) $\times$ 10

PF and NPF can be estimated using ratings by a trained observer, rated by workers using a Borg or visual analog scale (*see* TLV Documentation for definition), or measured using instrumentation, e.g., strain gauges or electromyography. In some cases, it can be calculated using biomechanical methods. These methods are intended to measure recurring peak forces. Random force peaks associated with noise that occur less than 10% of the time are disregarded.

Posture is included in the TLV to the extent that it affects strength. For instance, strength is reduced by the use of a pinch posture, wrist deviation, or forearm rotation and consequently normalized peak force will be increased.

The solid line in Figure 1 represents those combinations of force and hand activity level associated with a significantly elevated prevalence of musculoskeletal disorders. Appropriate control measures should be employed so that the force for a given level of hand activity is below the upper solid line in Figure 1. It is not possible to specify a TLV that protects all workers in all situations without profoundly affecting work rates. Therefore, an action limit is prescribed above for which general controls, including surveillance and training, are recommended.

Process

1. Identify the hand-activity tasks performed during the workday. There may be one or more and they should cumulatively represent four or more hours of work.
2. For each task, select a period of the task that represents an average activity. The selected period should include several complete work cycles. Videotapes may be used for documentation purposes and to facilitate rating of the job.
3. Rate the Hand Activity Level using the scale shown in Figure 2. Independent rating of jobs and discussion of results by three or more people can help produce a more precise rating than individual ratings.
4. Observe the job to identify forceful exertions and corresponding postures. Evaluate postures and forces using observer ratings, worker ratings, biomechanical analysis, or instrumentation. Normalized peak force is the required peak force divided by the representative maximum force for the posture multiplied by 10.
5. For jobs with multiple tasks, time-weighted averaging (TWA) may be used. One method is to determine the TWA of HAL across tasks and use the highest NPF observed among the tasks. A second method is to determine a TWA on the Peak Force Index (PFI) for each task (*see* Notes). A third method is to determine the TWA for NPF across all tasks and separately a TWA for HAL across all tasks.

Consideration of Other Factors

Professional judgment should be used to reduce exposures below the action limit if one or more of the following factors is present:

- sustained non-neutral postures such as wrist flexion, extension, wrist deviation, or forearm rotation;
- contact stresses;
- low temperatures; or
- vibration

Employ appropriate control measures any time the TLV is exceeded or an elevated incidence of work-related musculoskeletal disorders is detected.

Notes:

The actual TLV and action limit (AL) are represented by Figure 1. There are alternative methods for expressing the limit values, and some are described here. In all cases, they are limited to the range of HAL between 1 and 9.

1. **Equations for Lines**
   TLV: NPF = 5.6 – 0.56 $\times$ HAL
   Action Limit: NPF = 3.6 – 0.56 $\times$ HAL

   Or, equivalent description of lines:
   NPF_{TLV} = 0.56 (10 – HAL)
   NPF_{AL} = NPF_{TLV} – 2

2. **Peak Force Index (PFI)**
   A value greater than 1.0 means that the respective limit is exceeded.
   PFI_{TLV} = NPF/NPF_{TLV}
   PFI_{AL} = NPF/NPF_{AL}

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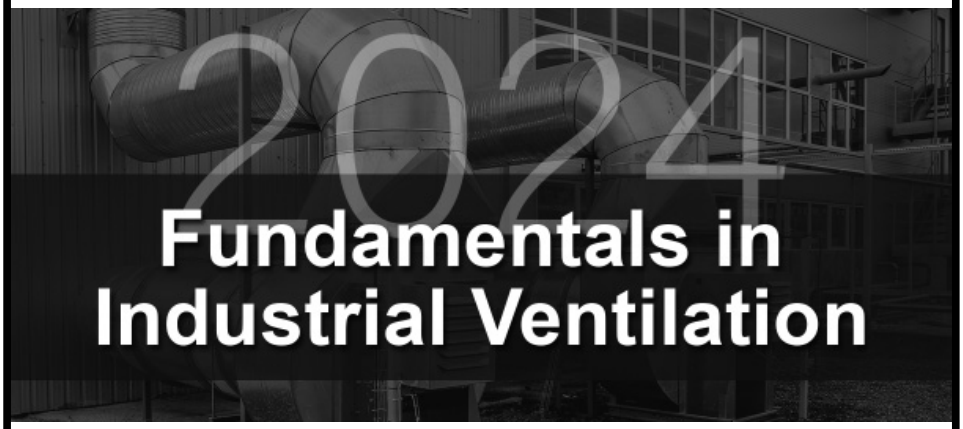

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LIFTING

(Documentation Date – 2019)

These TLVs recommend workplace lifting conditions under which it is believed nearly all workers may be repeatedly exposed, day after day, without developing work-related low back disorders associated with repetitive lifting tasks. There are individual and organizational risk factors that may influence the likelihood that an individual will experience low back and shoulder disorders.

Lifting TLVs

The TLVs consist of three tables with weight limits, in kilograms (kg), for 2-handed, mono-lifting tasks within 30 degrees of the sagittal [neutral] plane. A mono-lifting task is one in which the loads are similar and the starting and destination points are repeated, and this is the only lifting task performed during the day. Other manual material-handling tasks such as carrying, pushing, and pulling are not accounted for in the TLV, and care must be exercised in applying the TLVs under these circumstances.

These TLVs (Tables 1 through 3) are presented for lifting tasks defined by their durations, either less than or greater than 2 hours per day, and by their frequency, expressed in number of lifts per hour, as qualified in the *Notes* to each table.

In the presence of any factor(s) or working condition(s) listed below, professional judgment should be used to reduce weight limits below those recommended in the TLVs:

- High-frequency lifting: >360 lifts per hour.
- Extended workshifts: lifting performed for longer than 8 hours per day.
- High asymmetry: lifting more than 30 degrees away from the sagittal plane.
- Rapid lifting motions and motions with twisting (e.g., from side to side).
- One-handed lifting.
- Constrained lower body posture, such as lifting while seated or kneeling.
- High heat and humidity (*see* Heat Stress and Heat Strain TLVs).
- Lifting unstable objects (e.g., liquids with shifting center of mass or lack of coordination or equal sharing in multi-person lifts).
- Poor hand coupling: lack of handles, cut-outs, or other grasping points.
- Unstable footing (e.g., inability to support the body with both feet while standing).
- During or immediately after exposure to whole-body vibration at or above the TLV for Whole-Body Vibration (*see* the current TLV Documentation for Whole-Body Vibration).

Instructions for Users

1. Read the Documentation for the Lifting TLVs so you understand the basis for these TLVs and their limitations.
2. Classify task duration as less than or equal to a cumulative 2 hours per day or greater than a cumulative 2 hours per day. Task duration is the total length of time that a worker performs the task in 1 day.

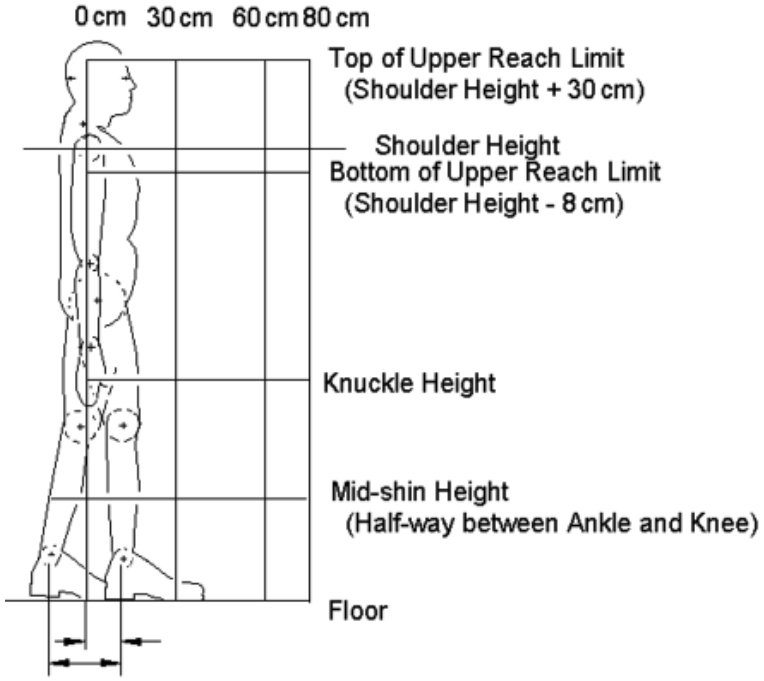

FIGURE 1. Graphic representation of hand location.

3. Determine the lifting frequency as the number of lifts a worker performs per hour.
4. Use the TLV table that corresponds to the duration and lifting frequency of the task.
5. Determine the vertical zone (Figure 1) based on the location of the hands at the start of the lift.
6. Determine the horizontal zone of the lift (Figure 1) by measuring the horizontal distance from the midpoint between the inner ankle bones to the midpoint between the hands at the start of the lift.
7. Determine the TLV in kilograms for the lifting task, as displayed in the table cell that corresponds to the vertical and horizontal zones in the appropriate table, based upon frequency and duration.
8. Consider load control at destination. If the load is placed at the destination in a controlled fashion (i.e., slowly or deliberately placed), repeat Steps 5 through 7 using the destination point instead of the start. The TLV is represented by the lower of the 2 limits.

These TLVs are designed to reduce the risk of low-back injuries associated with repeated lifting tasks. In addition to the low back, lifting and lowering tasks might expose other body regions to high stress. Depending on task parameters and specific posture requirements while lifting, joints such as shoulder, knee, elbow and wrist might be at equal or greater risk of injury than the low back. Additional research is needed to understand whole-body risk of injury from lifting. For example, expert opinion suggests that high frequency lifting while reaching at or above shoulder height might put a worker's shoulder at increased risk for injury even while the low-back loads are below the lifting TLVs. Practitioners are encouraged to exercise professional judgement and supplement the lifting TLVs with appropriate task-specific assessments to minimize injury risk to other body regions.

TABLE 1. TLVs for Lifting Tasks

≤2 Hours per Day with ≤60 Lifts per Hour

OR

>2 Hours per Day with ≤120 Lifts per Hour

	Horizontal Zone[a]		
Vertical Zone	**Close: <30 cm**	**Intermediate: 30-60 cm**	**Extended[b]:>60 to 80 cm**
Reach limit[c] or 30 cm above to 8 cm below shoulder height	16 kg	7 kg	No known safe limit for repetitive lifting[d]
Knuckle height[e] to below shoulder	32 kg	16 kg	9 kg
Middle shin to knuckle height[e]	18 kg	14 kg	7 kg
Floor to middle shin height	14 kg	No known safe limit for repetitive lifting[d]	No known safe limit for repetitive lifting[d]

Footnotes for Tables 1 through 3:

[a] Distance from midpoint between inner ankle bones and the load.

[b] Lifting tasks should not start or end at a horizontal reach distance more than 80 cm from the midpoint between the inner ankle bones (Figure 1).

[d] Routine lifting tasks should not be performed for shaded table entries marked "not known safe limit for repetitive lifting." While the available evidence does not permit identification of safe weight limits in the shaded regions, professional judgment may be used to determine if infrequent lifts of light weights may be safe.

[e] Anatomic landmark for knuckle height assumes the worker is standing erect with arms hanging at the sides.

TABLE 2. TLVs for Lifting Tasks

>2 Hours per Day with >12 and ≤30 Lifts per Hour

OR

≤2 Hours per Day with >60 and ≤360 Lifts per Hour

	Horizontal Zone[a]		
Vertical Zone	**Close: < 30 cm**	**Intermediate: 30-60 cm**	**Extended[b]:>60 to 80 cm**
Reach limit[c] or 30 cm above to 8 cm below shoulder height	14 kg	5 kg	No known safe limit for repetitive lifting[d]
Knuckle height[e] to below shoulder	27 kg	14 kg	7 kg
Middle shin to knuckle height[e]	16 kg	11 kg	5 kg
Floor to middle shin height	9 kg	No known safe limit for repetitive lifting[d]	No known safe limit for repetitive lifting[d]

See Notes in Table 1.

TLV–PA

TABLE 3. TLVs for Lifting Tasks

>2 Hours per Day with >30 and ≤360 Lifts per Hour

	Horizontal Zone[a]		
Vertical Zone	**Close: <30 cm**	**Intermediate: 30-60 cm**	**Extended[b]: 60 to 80 cm**
Reach limit[c] or 30 cm above to 8 cm below shoulder height	11 kg	No known safe limit for repetitive lifting[d]	No known safe limit for repetitive lifting[d]
Knuckle height[e] to below shoulder	14 kg	9 kg	5 kg
Middle shin to knuckle height[e]	9 kg	7 kg	2 kg
Floor to middle shin height	No known safe limit for repetitive lifting[d]	No known safe limit forrepetitive lifting[d]	No known safe limit for repetitive lifting[d]

See Notes in Table 1.

* ABOVE SHOULDER WORK
(Documentation Date – 2023)

These TLVs recommend workplace physical conditions for hand-intensive work performed at or above shoulder height under which it is believed that most workers may be repeatedly exposed, day after day, without developing work-related shoulder fatigue or disorders. Certain individual and organizational risk factors also may influence the likelihood that an individual will experience shoulder disorders.

The TLVs are based on the position of the hand relative to the shoulder when the hand applies force in a forward or upward direction. The location of the hand relative to the shoulder is measured in the direction of 3 axes: vertical (superior), anterior (forward), and medial-lateral (side) (Figure 1). The location of the measurement point at the shoulder is at the acromion (bony landmark on the top anterior part of the shoulder). The location of the measurement point at the hand is at the center of the palm at the knuckle joint (carpometacarpal joint) of the long finger. The wrist is assumed to be in a neutral wrist posture.

The TLVs for a 1-handed forward push force (in kilograms) are presented for different medial-lateral (ML) hand locations relative to the shoulder (Table 1). Each cell is the push force limit, in the forward direction, for a single exertion, based on the hand location relative to the shoulder (Figure 1). The TLVs for a 1-handed upward push force (in kilograms) are presented in Table 2.

The TLVs are based on epidemiologic, psychophysical, physiologic, and biomechanical studies and the values are selected so that the task can be safely accomplished by 75% of women and 95% of men. It should be noted that it is not possible to specify TLVs that protect all workers in all situations.

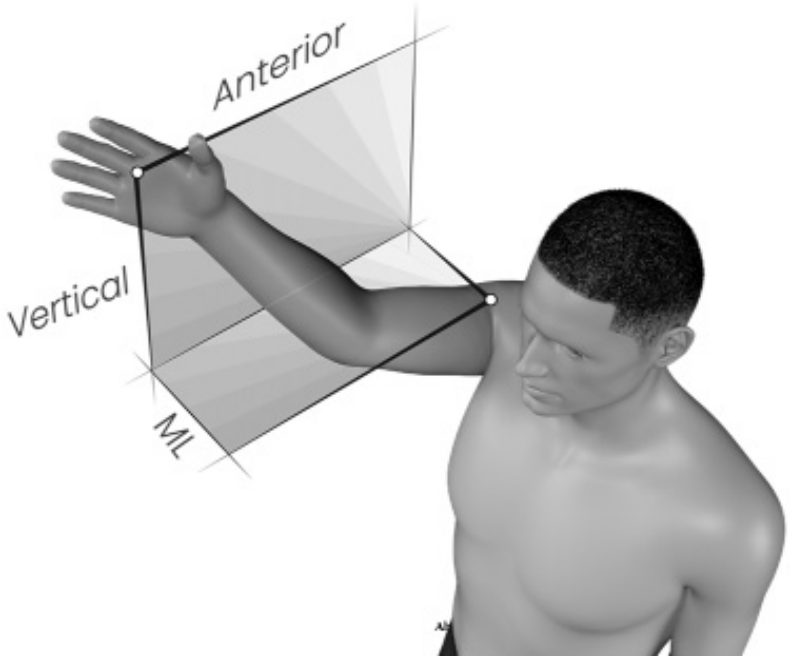

FIGURE 1. Location of the hand relative to the shoulder. In this figure, the hand location is 30 cm vertical, 40 cm anterior, and 20 cm lateral (ML=medial-lateral) relative to the shoulder.

TLV–PA

		ML = -20 cm					ML = 0 cm					ML = +20 cm					ML = + 40 cm		
	Anterior>	10	20	30	40	50	10	20	30	40	50	10	20	30	40	50	10	20	30
Vertical	50	0					0	0				0							
	40	3	4	5			2	3	5			2	3	4					
	30	6	7	8	9		5	7	8	9		6	6	7	7		4	4	
	20	6	7	8	10		7	7	8	10	13	6	7	7	9		5	5	6
	10	5	6	8	10	14		8	10	12	14	6	7	8	9	12	5	5	5
	0	4	7	9	11	15		8	10	11	12	6	8	9	11	14	6	5	5

One-handed forward push hand force TLVs (in kilograms) based on the hand location (in centimeters) relative to the shoulder. Vertical = hand height above the shoulder; Anterior = distance forward of the shoulder, ML = medial(−) / lateral(+) distance toward the center of a plane through the middle of the body or away from the center. The grey cells are hand locations that cannot be reached by the 50th percentile female adult.

		ML = −20 cm					ML = 0 cm					ML = +20 cm					ML = + 40 cm		
	Anterior>	10	20	30	40	50	10	20	30	40	50	10	20	30	40	50	10	20	30
Vertical	50	0					0	0				0							
	40	4	4	3			2	4	4			5	5	4					
	30	6	6	5	5		5	7	7	6		8	9	7	6		6	5	
	20	6	6	5	5		7	7	6	5	6	7	8	6	5		7	6	5
	10	7	6	5	5	7		7	6	5	5	6	7	6	4	5	6	5	4
	0	7	7	6	6	7		8	7	5	5	7	7	6	5	5	6	5	4

One-handed upward push hand force based on the hand location (cm) relative to the shoulder. Vertical = hand height above the shoulder; Anterior = distance forward of the shoulder, ML = medial(−) / lateral(+) distance toward the center of a plane through the middle of the body or away from the center. The grey cells are hand locations that cannot be reached by the 50th percentile female adult.

TLV-PA

If an above shoulder pushing task is performed repeatedly, shoulder fatigue may occur that will increase the risk of injury. For repetitive tasks, the TLV values should be reduced by applying a discounting factor using the upper limb localized fatigue TLV[1] and the estimated duty cycle.

If the force applied by the hand is above the TLV, then appropriate control measures should be used to decrease the risk of shoulder injury by reducing the height of the hand above the shoulder, the forward reach distance, the duration for which the hand is applying force, and/or the force necessary to complete the task.

This TLV does not consider other manual material handling tasks that may lead to fatigue or injury of the shoulder, such as pushing or pulling below shoulder height or lifting or carrying. If such tasks are performed in combination with over shoulder work, then an additional reduction in force limits may be needed. In addition, these TLVs do not consider potential injuries to the wrist, elbow, or back.

In the presence of the working conditions listed below, professional judgment should be used to reduce force limits to values below those recommended in the TLVs:

- If repeated pushing or pulling is performed for longer than an 8-hour work shift.
- If other pushing, pulling, lifting, or carrying tasks are required of the job.
- In conditions of high heat and humidity (see the Heat Stress and Strain TLVs).

Instructions for Users

1. Read the Documentation for Above Shoulder Work so you understand the basis for these TLVs and their limitations.
2. Determine the location of the hand relative to the shoulder and the direction of the applied force (forward and upward only) when performing the pushing task.
3. Use the TLV tables to determine the maximum recommended hand force for the task.
4. For repetitive above shoulder tasks, also apply the Upper Limb Localized Fatigue TLV to further limit the applied force.
5. Determine the maximum force applied by the hands during the pushing task using a force plate or force transducers or estimate the applied hand force based on the mass of the tool handled and the recommended force applied for the tool to function properly.

Reference

1. American Conference of Governmental Industrial Hygienists. Upper limb localized fatigue. In: 2022 TLVs and BEIs: Based on the documentation of the threshold limit values for chemical substances and physical agents and biological exposure indices. Cincinnati (OH): ACGIH; 2022. p. 204-208.

HAND-ARM VIBRATION
(Documentation Date – 2019)

Exposure to vibration may lead to hand-arm vibration syndrome (HAVS), a set of upper extremity disorders that include vascular, sensorineural, and musculoskeletal signs and symptoms. The Threshold Limit Value (TLV) for hand-arm vibration illustrated by the upper solid line in Figure 1 and tabulated in Table 1, refers to the daily vibration exposure [8-hour energy equivalent total value ***A*(8)**] of 5 m/s^2 that represents conditions under which it is believed that most workers may be exposed repeatedly without progressing beyond Stage 1 of the Stockholm Workshop Classification System for Vibration-Induced White Finger (VWF), also known as Raynaud's Phenomenon of Occupational Origin (*see* Vascular Assessment in Table 2). Vibration mitigation processes or controls should be employed that will maintain worker exposure below the TLV illustrated in Figure 1. It is not possible to specify a TLV that will be protective of all workers for all work situations, i.e., high force exertions, cold environments, and unusual postures. The action limit (AL) illustrated by the lower dashed line in Figure 1 and tabulated in Table 1 refers to an ***A*(8)** of 2.5 m/s^2. This limit represents conditions under which the risk of developing symptoms is very low for the large majority of workers. Therefore, the area between the AL and TLV corresponds to a caution zone that requires actions to control exposure, such as (1) the use of antivibration tools or gloves; (2) training of workers and supervisors on early symptoms of HAVS and the importance of keeping the worker's hands and body warm and reducing the vibration coupling between the hands and the vibrating tool to minimize vibration exposure, and (3) a conscientiously applied

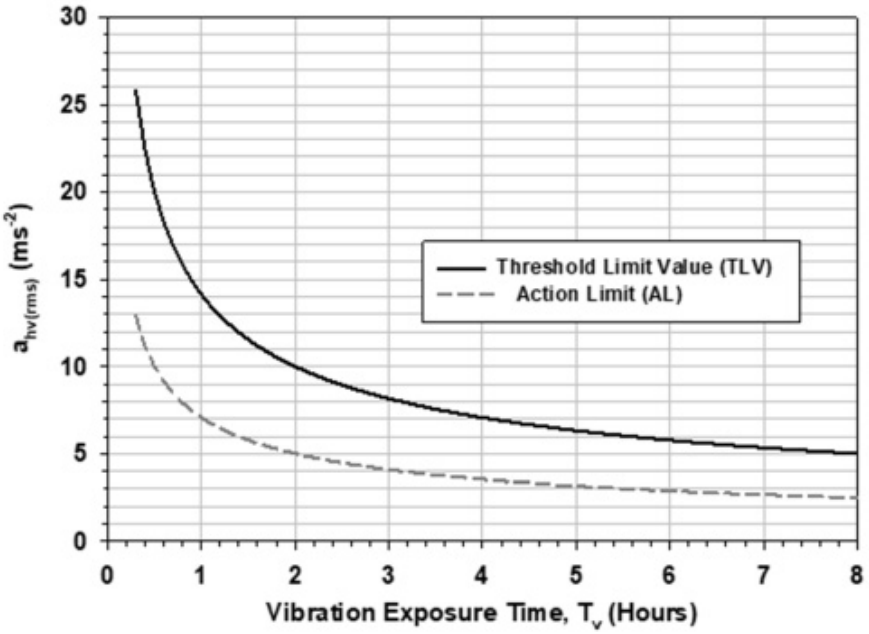

FIGURE 1. Threshold Limit Values (TLVs) and action limits (ALs) associated with ANSI 2.70 Daily Exposure Limit Values (DELV) and Daily Exposure Action Values (DEAV), respectively.

TABLE 1. TLV and AL Weighted Acceleration Levels

Vibration Exposure Time (hrs)	Weighted Acceleration ($a_{hv(rms)}$ ms^{-2})	
	TLV	AL
0.25 (15 min)	28.28	14.14
1.0	14.14	7.07
2	10.0	5.0
4	7.07	3.54
6	5.77	2.89
8	5.0	2.5

TLV at Time T_V (hrs): $a_{hv(TLV)} = 5.0\left(\frac{8}{T_v}\right)^{\frac{1}{2}}$

AL at Time T_v (hrs): $a_{hv(TLV)} = 2.5\left(\frac{8}{T_v}\right)^{\frac{1}{2}}$

Time Duration T_v (hrs) to reach TLV: $T_v = \frac{200}{a^2/_{hv(TLV)}}$

Time Duration T_v (hrs) to reach AL: $T_v = \frac{50}{a^2/_{hv(TLV)}}$

medical surveillance program. These recommendations have been derived mainly from epidemiologic data from forestry, mining, stone and metal-working occupations and should be used as guides in the control of hand–arm vibration exposure. Due to individual susceptibility, they should not be regarded as defining a boundary between safe and unsafe exposure levels.

Notes:

1. The TLV curve shown in Figure 1 coincides with the Daily Exposure Limit Values (DELVs) defined in ANSI S2.70 and the daily exposure limit value standardized to an 8-hour reference period (or 8-hour energy equivalent total value) defined in the European Union Directive 2002/44/EC.[1] The AL curve shown in Figure 1 coincides with the Daily Exposure Action Values (DEAVs) defined in ANSI S2.70 and the daily exposure action value (or 8-hour energy equivalent vibration total value) defined in the European Union Directive 2002/44/EC.[1]
2. ***A*(8)** is the vector sum of the 8-hour energy equivalent total value, constructed from the root-mean-square (rms) component accelerations measured in three orthogonal axes.
3. The frequency weighting factors provided in ISO 5349 (2001a, b) and ANSI S2.70 (2006) are considered the best available frequency weightings for the acceleration components for assessing hand–arm vibration exposure (*see* Figure 2).[1-3] However, studies suggest that the frequency weighting at frequencies above 16 Hz may not incorporate a sufficient safety factor, and caution must be applied when tools with high-frequency components are used.[4-13]

4. Acute exposures corresponding to measured frequency-weighted rms component accelerations either in compliance with or in excess of the TLVs for infrequent periods of time (i.e., intermittency: 1 day per week or several days over a 2-week period) may be less harmful than continuous exposure.[8-11]
5. Good work practices should be used and should include instructing workers to employ a minimum hand grip force consistent with safe operation of the power tool or process, to keep the body and hands warm and dry, to avoid smoking, and to use antivibration tools. As a general rule, gloves may dampen vibration at high frequencies (beyond 200 Hz).[8-10]
6. A vibration measurement transducer, together with its device for attachment to the vibration source, should weigh less than 15 grams and should possess a cross-axis sensitivity of less than 10%.[8-10,14,15]
7. The measurement by many (mechanically under-damped) piezoelectric accelerometers of repetitive and large displacement impact vibrations, such as those produced by percussive pneumatic tools, is subject to error. The insertion of a suitable, low-pass, mechanical filter between the accelerometer and the source of vibration with a cutoff frequency of at most 1,500 Hz (and cross-axis sensitivity of less than 10%) can help eliminate incorrect readings.
8. The manufacturer and type number of all apparatus used to measure vibration should be reported, as well as the value ***A*(8)**.[5,9,10,16,17]
9. The measurement of vibration should be performed in accordance with the procedures and instrumentation specified by ISO 5349-1 or ANSI S2.70. The procedures are summarized below.
   A. It is highly recommended that signal processing techniques be applied to generate the spectral content in each axis to identify the frequencies corresponding to major acceleration peaks. The spectra can be generated in either narrow frequency bands of constant bandwidth, or proportional bands no greater than one-third octave.
   B. A small and lightweight transducer should be mounted so as to accurately record one or more orthogonal components of the source vibration in the frequency range from 5 to 1,500 Hz (one-third octave frequency bands 6.3 to 1,250 Hz).
   C. Evaluation of vibration should be made for each applicable direction (X_h, Y_h, Z_h) since vibration is a vector quantity (magnitude and direction).
   D. Each component should be frequency-weighted by a filter network with gain characteristics specified for human-response vibration measuring instrumentation, to account for the change in vibration hazard with frequency.[2]

$$a_{hw} = \left(\frac{1}{T}\int_0^T a_{hw}^2(t)dt\right)^{\frac{1}{2}} \quad \textbf{(1)}$$

where: a_{hw} = The frequency-weighted rms acceleration associated with worker exposure time (T) in each respective direction (m/s^2 rms)

E. The weighted acceleration can also be obtained in the one-third octave frequency domain per Equation 2.

$$a_{hw} = \left(\sum_i [W_{hi}a_{hi}]^2\right)^{\frac{1}{2}} \quad \textbf{(2)}$$

F. In each direction, the magnitude of the vibration total value, a_{hv}, during normal operation of the power tool, machine, or work piece should be expressed by the root-sum-of-squares of the rms frequency-weighted component accelerations, in units of meters per second squared (m/s^2).

$$a_{hv} = \left(\left[a_{hwx}^2\right] + \left[a_{hwy}^2\right] + \left[a_{hwz}^2\right]\right)^{\frac{1}{2}} \quad \textbf{(3)}$$

G. Assessment of vibration exposure should be made by determining the 8-hour energy equivalent vibration total value of the frequency weighted rms acceleration components [alternatively termed the vector sum or frequency weighted acceleration sum]. The 8-hour energy equivalent vibration total value is termed the ***A*(8)**. These computations may be performed by commercially available human-response vibration measuring instruments.

$$A(8) = a_{hv}\left(\frac{T_v}{T_0}\right)^{\frac{1}{2}} \quad \textbf{(4)}$$

where: T_v = The total time in hours associated with the actual worker exposure (same as T in Equation 1)
T_0 = The reference time duration of 8 hours

H. The guidelines in ANSI S2.70 should be used if the vibration exposure is made up of several operations with different vibration magnitudes.[1]

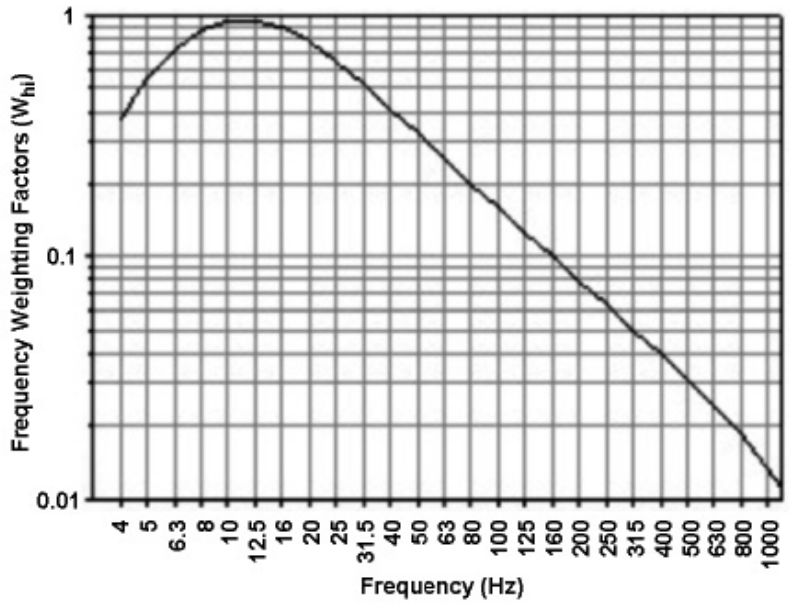

FIGURE 2. ISO Frequency Weighting Factors.[1,2]

TABLE 2. Stockholm Workshop HAVS Classification System for Cold-Induced Peripheral Vascular and Sensorineural Symptoms

	Vascular Assessment	
Stage	**Grade**	**Description**
0	—	No attacks
1	Mild	Occasional attacks affecting only thetips of ≥1 fingers
2	Moderate	Occasional attacks affecting distal and middle (rarely also proximal) phalanges of ≥1 fingers
3	Severe	Frequent attacks affecting ALL phalanges of most fingers
4	Very severe	As in Stage 3, with trophic skin changes in the finger tips

Note: Separate staging is made for each hand, e.g., 2L(2)/1R(I) = Stage 2 on left hand in 2 fingers: Stage 1 on right hand in 1 finger.

Sensorineural Assessment	
Stage	Symptoms
0 SN	Exposed to vibration but no symptoms
1 SN	Intermittent numbness, with or without tingling
2 SN	Intermittent or persistent numbness, reducing sensory perception
3 SN	Intermittent or persistent numbness, reducing tactile discrimination and/or manipulative dexterity

Note: Separate staging is made for each hand.

where: a_{hw} = The frequency-weighted rms acceleration associated with the exposure time in each respective direction (m/s^2 rms)
W_{hi} = The ISO/ANSI frequency weighting factor for the i^{th} one-third octave frequency band (*see* Figure 2)
a_{hi} = The rms acceleration in the i^{th} one-third octave frequency band associated with the exposure time in each respective direction (m/s rms)

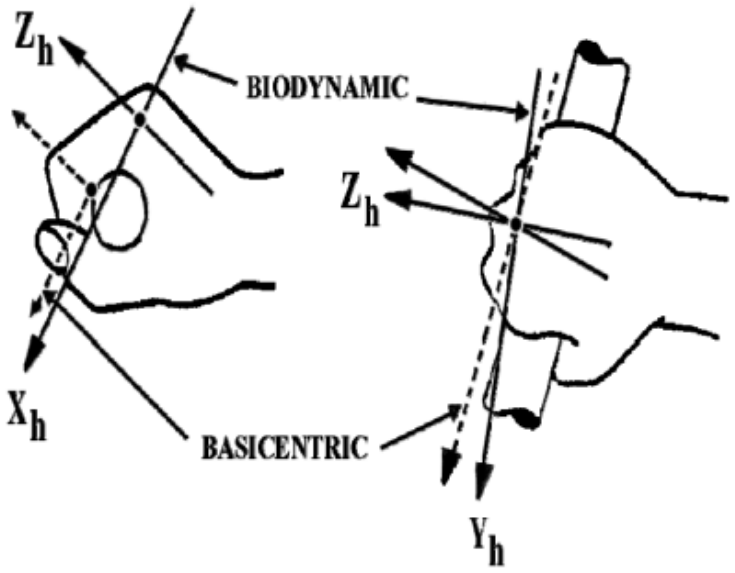

FIGURE 3. Biodynamic and basicentric coordinate systems for the hand, showing the directions of the acceleration components.[1,2]

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UPPER LIMB LOCALIZED FATIGUE (Documentation Date – 2022)

The TLV in Figure 1 is recommended for workplace tasks that require the use of the upper limbs, to which it is believed that most healthy workers may be exposed, day after day, to maintain their work capacity and normal performance for the duration of the workday without experiencing excessive or persistent upper limb musculoskeletal fatigue. Individual, environmental and other workplace factors may influence the likelihood that fatigue will be experienced as a pain or reduced upper limb motor control. This recommended TLV may not be protective for persons with preexisting musculoskeletal disorders.

Localized fatigue is a complex phenomenon based on multiple factors, mechanisms, and outcomes that results from exertion of the body and affects our comfort and the ability of our musculoskeletal system to perform activities of work, daily living and leisure. Fatigue may be experienced as localized discomfort, pain, decreased strength, tremor or other symptoms or signs of reduced motor control. Physical exertions can cause fatigue that is brief, lasting for just a few hours, or fatigue that may persist for 24 hours or more or, in extreme cases, tissue damage that can require several days or weeks for complete recovery. For purposes of this guideline, fatigue refers to discomfort or reduced upper limb function that occurs within 24 hours after sustained or repeated exertions of the hands and arms. Signs or symptoms that persist beyond 24 hours should be investigated as possible work-related musculoskeletal disorders. Fatigue may be a precursor to chronic soft tissue injuries.

A certain amount of localized fatigue, in and of itself, is not detrimental. Fatigue is a fact of life and a normal physiological response and may play an important role in adaptation of musculoskeletal tissues to physical stresses and unaccustomed work, but fatigue should not persist from one workday to the next or interfere with activities of work or daily living. As with any activity, workers may require several days or weeks to mentally and physically adapt to a new job. Abnormal symptoms may be experienced during this period of adaptation.

Localized fatigue that occurs during the workday should be reversibly resolved during the daily breaks from work, allowing for normal work function and typical life activities beyond work.

The recommended limits apply specifically to the upper limb: the hand/wrist, forearm, elbow, and shoulder. There are underlying biomechanical and behavioral differences between the upper limb, trunk, and lower limbs and care should be exercised in generalizing recommended limits for the upper limb to other body parts.

Workload Patterns

Work performance is measured as the ability to repeat and/or sustain biomechanical loads to reach for, grasp, hold, and use or manipulate work objects. Loads, used in this context, refers to the exertion of forces and moments to support the weight of the body and work objects or to grasp, hold and manipulate work objects as necessary to meet the job requirements. Rapid body motions may briefly increase or decrease the loads during work due to acceleration and deceleration, but most fatigue computations are based on static or "quasi static" conditions where these dynamic effects are negligible.

Loads can be normalized to strength by dividing the applied forces or moments by the strength of the corresponding joint and posture of an individual or population of interest. Strength refers to the maximum force or moment that can be voluntarily generated by the body segment of interest. Normalized loads are expressed as a fraction between 0 and 1, on a scale of 0 to 10, or as a percentage from 0 to 100%. These normalized loads are also frequently expressed as a Percent of Maximum Voluntary Contraction (%MVC).

Loads may be estimated from observations, perceived exertions estimated by workers, direct measurements, indirect measurements (e.g., electromyography) and biomechanical computations. Worker strength can be measured directly or estimated from population studies or biomechanical models. The best method will depend on the type of work being performed and the characteristics of the workers who perform the job. Procedures for analysis of load patterns are documented in the literature.

The equation for the TLV in Figure 1 is:

$$\%MVC = (100\%) \bullet (-0.143 \ln (DC/100\%) + 0.066)$$

where %MVC is the percent of maximum strength or effort of the hand, elbow or shoulder and DC is the duty cycle expressed as a percent of the total work cycle. The duty cycle is the percent of time over a work cycle or a certain time period that force is applied

The TLV can also be expressed as:

$$\%DC = (100\%) \bullet e^{((0.066 - (\%MVC/100\%))/0.143)}$$

The TLV fatigue curve can be used to compute acceptable percent duty cycle for a given force (%MVC) or an acceptable %MVC for a given percent duty cycle. The TLV applies to duty cycles within the range of 0.5% to 90%. The TLV is intended for cyclical work normally performed for 2 or more hours per day. If a worker does multiple tasks that are each 2 hours or more, none of the tasks should exceed the TLV. Static exertions of the hand, elbow or shoulder would not be expected to exceed 20 minutes.

The minimum recovery time (RT) from an exertion performed during repetitive tasks can be estimated using:

$$RT = (ET / e^{((0.066-\%MVC)/0.143)}) - ET$$

where ET is the exertion time. Duty cycle (DC) = ET / (ET+RT). This equation can be applied over the applicable range of the TLV, which is 0.5% to 90% DC, which corresponds to exertion levels ranging from approximately 10% to 80% MVC.

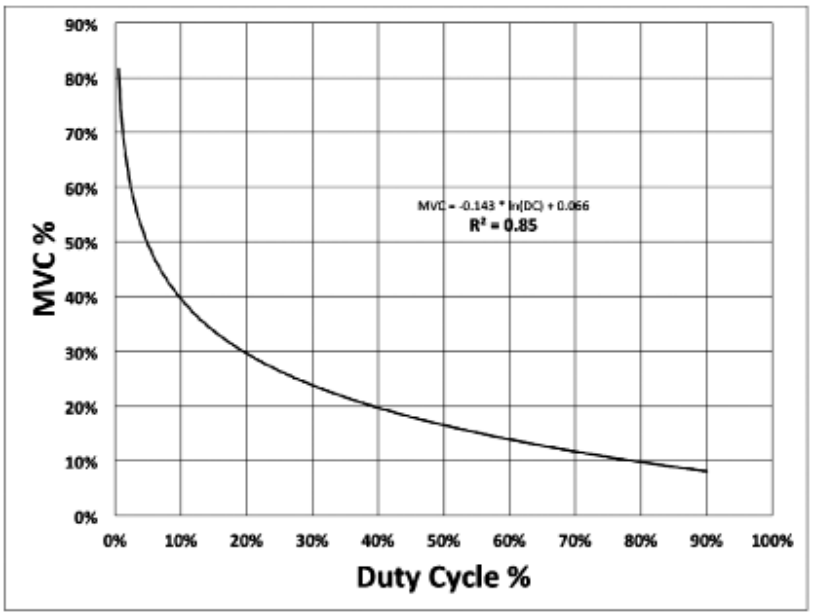

FIGURE 1. Fatigue TLV for MVC (%) versus duty cycle (%).

* WHOLE-BODY VIBRATION
(Documentation Date – 2023)

The Threshold Limit Values (TLVs), represented by the solid line in Figure 1 and tabulated in Table 1 refer to the vector sum of the daily overall weighted root-mean-square (RMS) acceleration magnitudes of mechanically induced whole-body vibration (WBV) in 3 orthogonal axes. Seated operator or occupant daily exposures shall remain below the TLV curve for the expected daily exposure duration occurring within a 24-hour period. The action levels (ALs) represented by the dashed line in Figure 1 and tabulated in Table 1, also refer to the vector sum of the daily overall weighted RMS acceleration magnitudes of mechanically induced WBV in 3 orthogonal axes. It is highly recommended that vibration mitigation activity be undertaken to reduce any operator or occupant daily exposures that fall within the region bounded by the TLV curve and AL curve for the expected daily exposure duration occurring within a 24-hour period. It is noted that unknown psychological or physiological influences may affect an individual's susceptibility to health risk. Although the TLV and AL curves may be used as a guide in the control of WBV exposure, they should not be regarded as defining a distinct boundary between safe and dangerous levels.

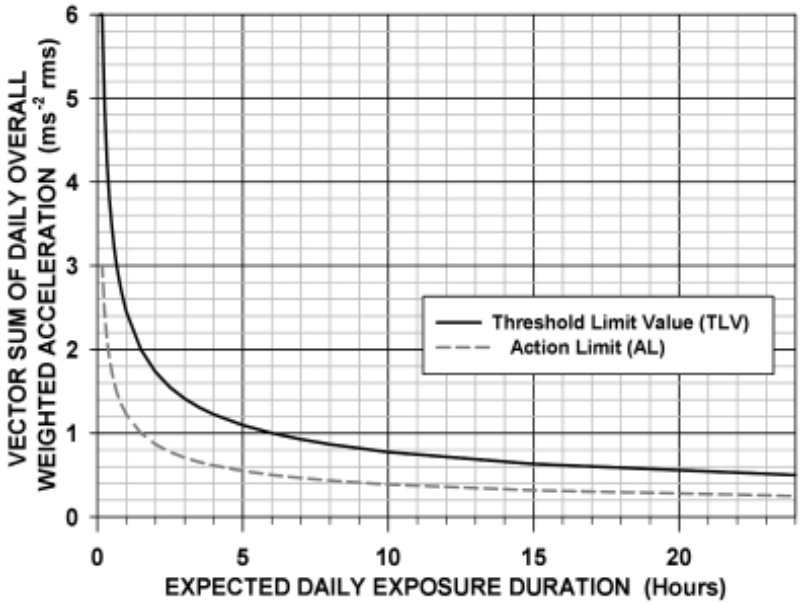

FIGURE 1. Threshold Limit Values (TLVs) and Action Limits (ALs) associated with the upper boundary and lower boundary of the ISO 2631-1 Health Guidance Caution Zones, respectively.[1,2] ***Note:*** Values are constant for exposures at and below 10 minutes (0.17 h).

TABLE 1. TLV and AL Vector Sums of the Overall Weighted RMS Accelerations (ms^{-2} rms)

Expected Daily Exposure Duration (hours)	TLV (ms^{-2} rms)	AL (ms^{-2} rms)
0.17	6.00	3.00
0.50	3.46	1.73
1.00	2.45	1.22
2.0	1.73	0.87
4.0	1.22	0.61
8.0	0.87	0.43
12.00	0.71	0.35
16.00	0.61	0.30
24.00	0.50	0.25

TLV at Time *T* (hrs): $TLV = \frac{2.45}{\sqrt{T}}$ (ms^{-2}rms)

AL at Time *T* (hrs): $AL = \frac{1.22}{\sqrt{T}}$ (ms^{-2}rms)

Note: Equations do not apply for exposure durations shorter than 10 minutes or greater than 24 hours

TLV–PA

Notes:

1. The TLV curve coincides with the upper boundary of the Health Guidance Caution Zones defined in ISO 2631-1.[1,2] The TLVs refer to the maximum vector sum of the overall weighted RMS accelerations for a given expected daily exposure duration to which it is believed a majority of operators and occupants of land, air, and water vehicles may be exposed within a 24-hour period with a low probability of health risks. Exposures falling above the TLV or upper ISO boundary are associated with likely health risks. The AL curve coincides with the lower boundary of the Health Guidance Caution Zones defined in ISO 2631-1.[1,2] Exposures falling within the lower boundary (dashed line) and upper boundary (solid line) in Figure 1 for the expected daily exposure duration within a 24-hour period have been associated with the potential for health risks. Exposures falling below the AL or lower ISO boundary are associated with unlikely health risks. The procedures described in this Documentation apply to translational accelerations of the seated upright operator or occupant for assessing health risk in accordance with ISO 2631-1.[1,2]
2. Vibration acceleration is a vector with magnitude expressed in units of meters per second squared (ms^{-2}). The gravitational acceleration, "g" = 9.81 ms^{-2}. The biodynamic coordinate system used for measuring the accelerations of the seated operator or occupant is illustrated in Figure 2.
3. The TLVs and ALs associated with the vector sum of the daily overall weighted RMS accelerations may underestimate the health risk for vibration with occasional or substantial shocks, or transient vibration. ISO 2631-1 provides guidance on alternative methods. These methods include the Vibration Dose Value (*VDV*). ISO 2631-5 provides guidance for assessing vibration with multiple shocks, and should be considered for assessing

exposures that include shocks or impacts that exceed 9.81 ms^2 (1 g peak).[3] The alternative methods should be used in addition to the RMS method (see Notes 7 and 8). The TLV and AL are limited to the seated operator or occupant and are not intended for use in fixed buildings, in offshore structures, or in large ships.

4. A summary of WBV measurement procedures follows[1,2]:
   A. Three light-weight accelerometers (or a triaxial accelerometer), each with a cross-axis sensitivity of less than 10%, are mounted orthogonally in the center of a hard rubber disc, per ISO 10326-1.[4] The total weight of the instrumented rubber disc and cables should not exceed 400 g.
   B. At a minimum, and for health risk assessment, one instrumented rubber disc should be placed on the top of the operator's or occupant's seat and the interface between the buttocks and contacted seat or cushion surface. A second instrumented rubber disc may be placed at the interface between the operator's or occupant's back and the contacted seat back, particularly if a comfort assessment is desirable (see ISO 2631-1, Section 8.2).[1,2]
   C. At the interface measurement location, continuous acceleration measurements should be simultaneously obtained and recorded along the three orthogonal axes (x, y, z) shown in Figure 2 (seat surface/pan and seat back [optional]). The duration of the measurement should ensure measurement accuracy and be representative of the operator's or occupant's vibration exposure over the expected daily exposure duration.
5. A summary of WBV data processing procedures, including the calculation of the overall weighted RMS acceleration in each axis (x, y, z) and the vector sum of the overall weighted RMS accelerations for assessing health risk follows:
   A. It is highly recommended that signal processing techniques be applied to generate the unweighted spectral content in each axis to identify the frequencies corresponding to major acceleration peaks. The spectra can be generated in either narrow frequency bands of constant bandwidth, or proportional bands no greater than one-third octave.
   B. At a minimum for health risk assessment, the acceleration measurements obtained for each axis at the buttocks-contacted seat surface should be recorded and processed in accordance with ISO 2631-1 for the seated operator or occupant using the basic evaluation method and the frequency weightings and multiplying factors for health risk.[1,2] This can be done in the time domain or frequency domain using narrow band or one-third octave band data as mentioned above. The frequency weighting curves for health risk are illustrated in Figure 3. The multiplying factors (k_l) for health risk are given below for the respective direction or axes. The frequency range is 0.5 to 80 Hz. This

yields the overall weighted RMS acceleration in each axis (x, y, z). The calculation in the time domain is illustrated in Equation 1[1,2]:

$$a_{wl} = k_l \left(\frac{1}{T} \int_0^T a_{wl}^2 (t) dt \right)^{\frac{1}{2}} \quad (1)$$

where:

a_{wl} = The overall weighted RMS acceleration in the *l*-axis, (*l* = x, y, or z) (ms^{-2} RMS) associated with the duration of the measurement, *T* (s)

k_l = The multiplying factor for direction *l* (*k* = 1.4 for *l* = x, y; *k* = 1.0 for *l* = z)

$a_{wl}(t)$ = The weighted acceleration as a function of time between 0.5 and 80 Hz (ms^{-2})

T = Duration of the measurement(s)

The calculation in the frequency domain is illustrated in Equation 2:

$$a_{wl} = k_l \left(\sum [W_{li} a_{li}]^2 \right)^{\frac{1}{2}} \quad (2)$$

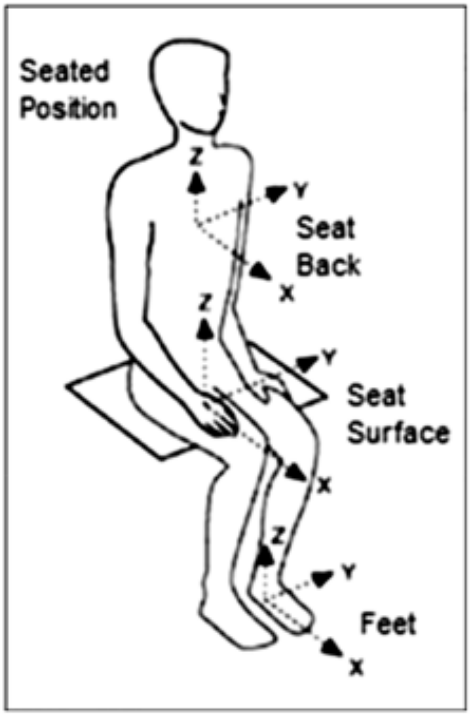

FIGURE 2. Biodynamic coordinate system for the seated posture.[1,2]

where:

a_{wl} = The overall weighted RMS acceleration in the l-axis, (l = x, y, or z) (ms^{-2} rms)

k_l = The multiplying factor for direction *l* (*k* = 1.4 for *l* = x, y; *k* = 1.0 for *l* = z)

W_{li} =The frequency weighting for the *l*-axis at the respective narrow band frequency or 1/3 octave band center frequency, *i*, from 0.5 to 80 Hz

a_{li} =RMS acceleration value in the *l*-axis at the respective narrow band frequency or 1/3 octave band center frequency, *i*, from 0.5 to 80 Hz (ms^{-2} RMS)

If the vibration measured during *T* is representative of the operator's or occupant's daily exposure in a 24-hour period then:

$$a_{wl,daily} = a_{wl} \quad (3)$$

where:

$a_{wl,daily}$ = Daily overall weighted RMS acceleration in the *l*-axis (*l* = x, y, or z) (ms^{-2} RMS) associated with the expected daily exposure duration, T_e

If the daily vibration exposure is from more than one source (use of multiple vehicles) or from functionally different exposure periods (vibration of different magnitudes and durations) occurring within contiguous 24 hours, the daily overall weighted RMS acceleration in each direction, x, y, and z, can be calculated from a combination of these exposures as follows:

$$a_{wl,e} = \left(\frac{\sum \left[a_{wlj}^2 \cdot T_j \right]}{\sum T_j} \right)^{\frac{1}{2}} \quad (4)$$

where:

a_{wlj} = The overall weighted RMS in the *l* = x, y, or z direction for exposure period *j* (ms^{-2} RMS) (from Equations 1 or 2)

T_j = The expected daily exposure duration for source or exposure period *j* (s)

The expected daily exposure duration for multiple periods of exposure is defined as:

$$T_e = \sum_j T_j \quad (5)$$

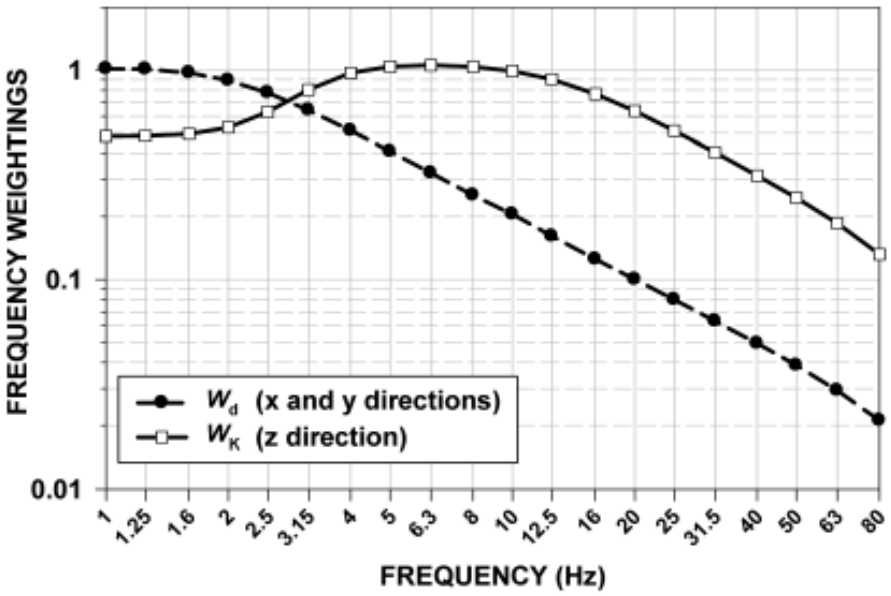

FIGURE 3. ISO 2631-1 Frequency weightings W_d (x and y directions) and W_K (z direction).[1]

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C. The daily overall weighted RMS accelerations may or may not be similar along the x, y, and z translational axes or directions. Therefore, the combined motion of all three orthogonal axes is calculated as a vector sum of the overall weighted RMS accelerations, $a_{v,daily}$:

$$a_{v,daily} = \left(\begin{matrix} \left[a_{wx,daily}\right]^2 + \left[a_{wy,daily}\right]^2 \\ +\left[a_{wz,daily}\right]^2 \end{matrix} \right)^{\frac{1}{2}} \quad (6)$$

where:

$a_{v,daily}$ = vector sum of the daily overall weighted RMS accelerations (ms^{-2} RMS) in the 3 orthogonal axes associated with the daily expected exposure duration, T_e.

6. A summary of the analysis procedure is as follows:
   A. The vector sum of the daily overall weighted RMS accelerations, $a_{v,daily}$, is compared to the TLVs and ALs illustrated in Figure 1 for the expected daily exposure duration, T_e, to assess if the TLV is exceeded (likely health risk), if the daily exposure falls between the TLV and AL (potential health risk), or if the daily exposure falls below the AL (unlikely health risks).
   B. It may be desirable to calculate the daily vibration exposure (within a 24-hour period) standardized to an 8-hour reference period as fol-

lows:

$$a_{v,daily}(8) = a_{v,daily}\left[\left(\frac{T_e}{T_0}\right)^{\frac{1}{2}}\right] \quad (7)$$

where:

T_0 = The reference duration of 8 hours or 28,800 seconds

The $a_{v,daily}(8)$ can then be evaluated using Figure 2 or Table 1 at T_0 or 8 hours.

7. With reference to ISO 2631-1,[1] the weighted RMS method described above may underestimate the effects of vibration containing occasional or substantial shocks, or transient vibration. In addition to the RMS method, the fourth power *VDV* may be calculated in each direction as:

$$VDV_l = k_l\left(\int_0^T [a_{wl}(t)^4]\,dt\right)^{\frac{1}{4}} \quad (8)$$

It is noted that, unlike the overall weighted RMS acceleration calculated in accordance with Equations 1 and 2, the VDV_l is dependent on the duration of the measurement. If the measurement duration, *T*, associated with the *VDV* is not equal to the expected daily exposure duration, *T*e , but the measured vibration is representative of the exposure occurring during *T*e, then:

$$VDV_{l,daily} = VDV_l\left[\left(\frac{T_e}{T}\right)^{\frac{1}{4}}\right] \quad (9)$$

If the daily vibration exposure is from more than one source (use of multi ple vehicles) or from functionally different exposure periods (vibration of different magnitudes and durations) occurring within contiguous 24 hours, the daily VDV_l can be calculated from a combination of these exposures as follows:

$$VDV_{l,daily} = \left(\sum_j VDV_{lj}^4\right)^{\frac{1}{4}} \quad (10)$$

where:

VDV_{lj} = the VDV_l associated with exposure period *j*

When using this method, the TLV in any direction is defined by a VDV_l value of 17.0 $ms^{-1.75}$ and shall not be exceeded for the exposure dura tion. The AL in any direction is defined by a VDV_l value of 8.5 $ms^{-1.75}$. It is highly recommended that vibration mitigation activity be undertaken to reduce any VDVl falling between 8.5 and 17.0 ms-1.75. Note that neither the ISO 2631-1 nor ACGIH defines a vector sum for the *VDV*. The VDV method should not be applied to exposures lasting more than 6 hours. For

exposures lasting more than 6 hours, the TLVs and ALs associated with the RMS method should be applied to assess health risk.

8. For vibration exposure with shocks or impacts that exceed 9.81 ms (1 g peak), the guidelines in ISO 2631-5 should be followed to calculate the stress variable, *R*. The TLV is defined by an *R* value of 1.6 and should not be exceeded. This *R* value corresponds to a relatively low risk of injury. ISO 2631-5 also provides an alternative method for exposures containing shocks or impacts at or below 9.81 ms (1 g peak). These methods should be applied in addition to the RMS method described in Notes 1-6 to determine if any TLV has been exceeded.
9. When the daily exposure duration is unknown or expected to vary on different days, and the assumption can be made that the estimate of the vector sum of the daily overall weighted RMS accelerations, $a_{v,daily}$, is expected to represent the exposure associated with most daily exposures, the time duration, *T*, to reach the TLV can be estimated as:

$$T = \frac{(6.0)}{a_{v,daily}^2} \quad (11)$$

Likewise, the time duration, *T*, to reach the AL can be estimated as:

$$T = \frac{(1.5)}{a_{v,daily}^2} \quad (12)$$

It is noted that the reference to *T* in Equations 11 and 12 is different from the reference to *T* as the measurement duration.

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References

1. International Standards Organization (ISO). Mechanical vibration and shock: Evaluation of human exposure to whole-body vibration—Part 1: General requirements. ISO 2631-1:1997. Geneva, (CH): ISO. 1997.
2. International Standards Organization (ISO). Mechanical vibration and shock: Evaluation of human exposure to whole-body vibration–Part 1: General requirements, amendment 1. ISO 2631-1:1997/Amd.1:2010ISO. Geneva (CH): ISO. 2010.
3. International Standards Organization (ISO). Mechanical vibration and shock-evaluation of human exposure to whole-body vibration–Part 5: Method for evaluation of vibration containing multiple shocks. ISO 2631-5:2018. Geneva (CH): 2018.
4. International Standards Organization (ISO). Mechanical vibration and shock: Laboratory method for evaluating vehicle seat vibration –Part 1: Basic requirements. ISO 10326-1:2016. Geneva (CH): 2016.

NOTICE OF INTENDED CHANGE — † PUSH-PULL

(Documentation Date – 2023)

These TLVs recommend workplace hand force conditions for whole body pushing or pulling tasks under which it is believed that most workers may be repeatedly exposed, day after day, without developing work-related low back disorders. Examples of pushing and pulling tasks include moving carts, dollies, or pallet jacks. It is not possible to specify TLVs that protect all workers in all situations. There are individual and organizational factors that may influence the likelihood that an individual will experience a low back disorder. These TLVs do not consider potential injuries to the wrists, shoulders, or lower extremities related to pushing and pulling tasks or the metabolic demands of the task.

The TLVs for hand force limits in kilogram-force (kg-force) for pushing or pulling in a straight line are presented in Table 1 for 2-handed pushing, 2-handed pulling and 1-handed pulling tasks. The TLVs vary based on the height of the hand above the floor (in centimeter) while pushing or pulling.

Maximum push or pull forces measured are compared to the appropriate TLV. The push or pull force measurements should be made for movements estimated to require the greatest forces. This is usually the initial force applied for the task, but other movements should be considered, such as pushing or pulling a cart up a ramp or over an uneven surface.

Appropriate control measures should be used so that the measured push or pull forces are below the TLVs.

In the presence of any of the special working conditions listed below, professional judgment should be used to estimate how much to reduce the hand force limits below the TLVs:

- Pushing or pulling performed for longer than 7 hours in a day.
- More than 1,000 pushing or pulling exertions in a day.
- Other material handling tasks that may contribute to the risk of musculoskeletal injury, e.g., lifting, lowering, or carrying.
- High heat and humidity conditions in which the metabolic demands may contribute to loss of capacity and coordination (see the Heat Stress and Strain TLVs).

Instructions for Users

1. Read the Documentation for the Push-Pull TLVs to understand the basis for these TLVs and their limitations.

TABLE 1. TLVs for push and pull force (kg-force) based on hand height (cm) above the floor.

Hand Height Above Floor (cm)	2-Handed Push TL (kg-force)	2 Handed Pull TLV (kg-force)	1-Handed Pull TLV (kg-force)
120	30	32	19
115	29	31	20
110	27	30	20
105	25	29	20
100	24	28	20
95	24	25	20
90	23	22	19
85	22	20	18
80	21	18	17

THERMAL STRESS

COLD STRESS

(Documentation Date – 2018)

Introduction

The cold stress TLVs are intended to protect workers from the most severe effects of cold stress (hypothermia and frostbite) and to describe exposures to cold working conditions under which it is believed that nearly all workers can be repeatedly exposed without adverse health effects. The TLV objective is to prevent the deep body core temperature from falling below 36°C (96.8°F) and to prevent frostbite to body extremities. Fatal exposures to cold among workers have almost always resulted from accidental exposures involving failure to escape from low environmental air temperatures or from immersion in low temperature water. Preventing cold injuries is best done through a risk management strategy that assesses cold hazards and then develops and implements controls to mitigate the effects of the cold environment. Figure 1 presents a risk management process to use in cold-weather environments. Figure 2 shows the types of cold injuries.

Hypothermia Prevention

Hypothermia is defined as a core body temperature below 95°F (35°C). The physiological changes that occur as the temperature goes below this value are presented in Table 1. In an occupational setting, workers should be protected from cold exposure so that the deep core temperature does not fall below 36°C (96.8°F); lower body temperatures can result in reduced mental alertness and rational decision making. As the core body temperature goes below 91.4°F (33°C), workers can become severely debilitated. Hypothermia is a life-threatening condition and must be treated promptly.

Early symptoms of hypothermia include feeling cold, shivering, and exhibiting signs of apathy and social withdrawal. Supervisors and workers should be aware of these early symptoms so that proper preventative measures can be taken at this time. More pronounced hypothermia manifests as confusion or sleepiness, slurred speech, and a change in behavior or appearance. Exposure to cold should be immediately terminated for any workers when severe shivering becomes evident.

Since prolonged exposure to extremely cold air, cold-wet conditions, and cold water immersion can lead to hypothermia, whole-body protection must be provided. Cold, wet, and windy weather poses the greatest risk for developing hypothermia. Figure 3 presents the clothing insulation required as a function of air temperature and work rate. As seen, the amount of insulation increases as the ambient temperature and work rate decrease. In wet weather, it is imperative that the outer layer of clothing be waterproof. In windy weather, a wind-proof outer layer is needed. Table 2 presents different activities and their associated work rate in metabolic equivalents (METs). This table can be used in conjunction with Figure 3 to determine the approximate clothing insulation required at different air temperatures.

Cold-water immersion can cause life-threatening hypothermia in a matter of hours if proper protection is not worn. Table 3 presents the amount of time

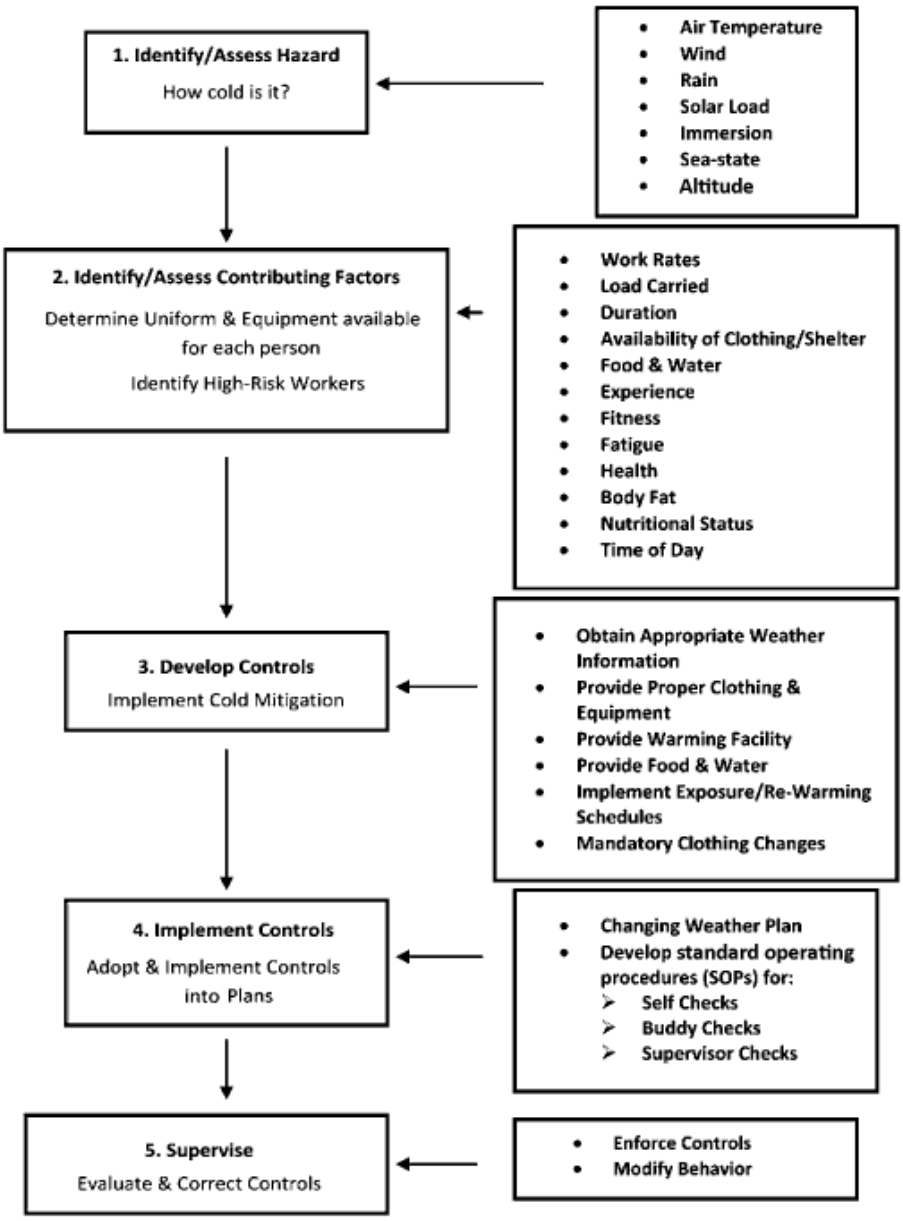

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FIGURE 1. Risk management process for evaluating cold stress and strain.
Source: Department of the Army.[1]

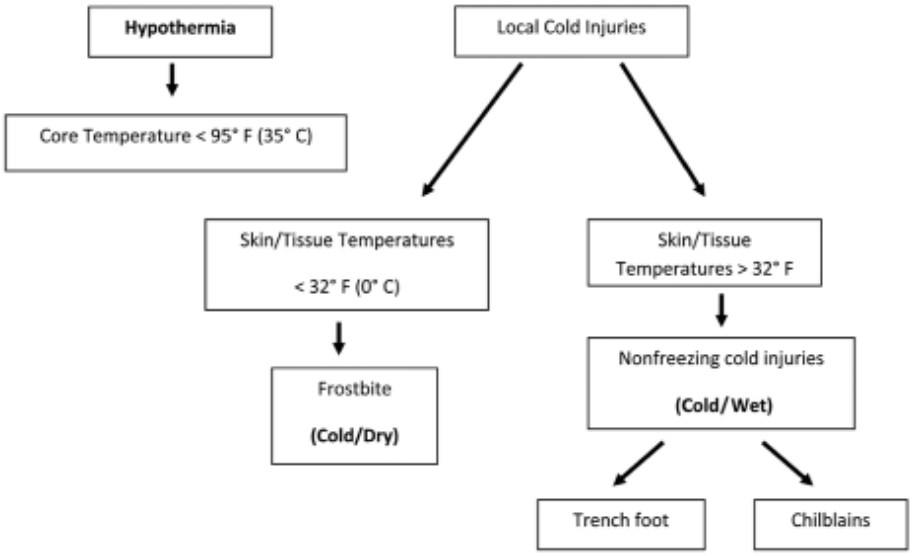

FIGURE 2. Types of cold injuries.

Source: Department of the Army.[1]

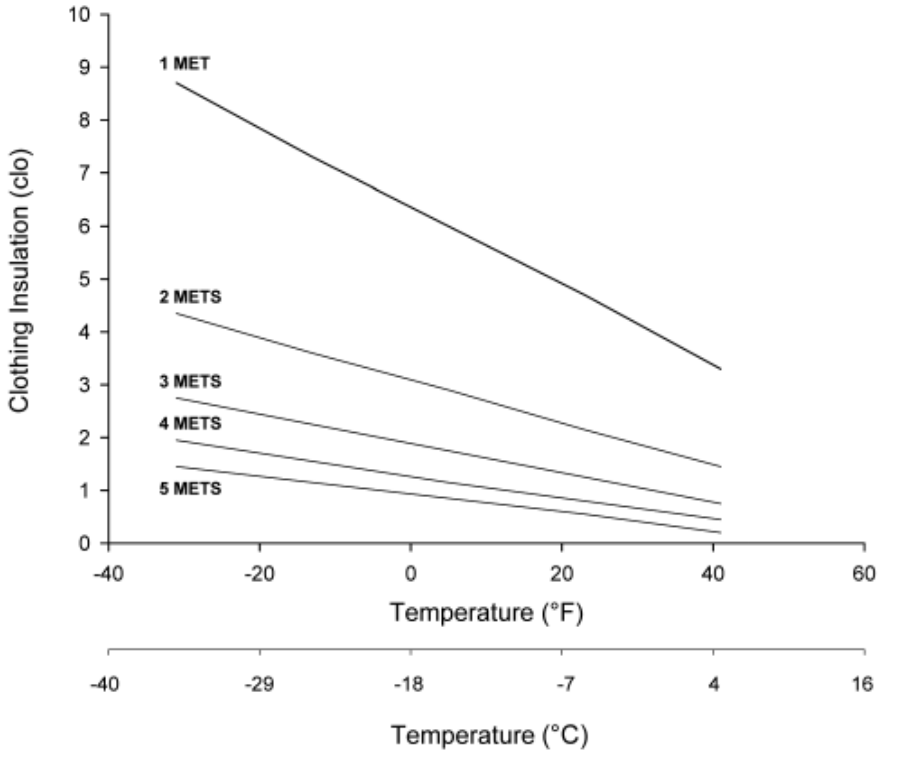

FIGURE 3. Approximate amount of clothing insulation needed at different air temperatures and physical activity levels. Wind speed is assumed to be less than 5 mph (2.2 m/s). 1 MET refers to energy expenditure at rest (58.2 W/m^2). One clo of insulation is the clothing necessary to allow a resting person to be comfortable when the air temperature is 21°C (70°F).

Source: Castellani et al.[2]

TABLE 1. Core Temperature and Associated Physiological Changes that Occur as Core Temperature Falls. Individuals Respond Differently at Each Level of Core Temperature

Stage	Core Temperature		Physiologic Changes
	°F	°C	
Normothermia	98.6	37.0	
Mild hypothermia	95.0	35.0	Maximal shivering; increased blood pressure
	93.2	34.0	Amnesia; dysarthria; poor judgment: behavior change
	91.4	33.0	Ataxia; apathy
Moderate hypothermia	89.6	32.0	Stupor
	87.8	31.0	Shivering ceases; pupils dilate
	85.2	30.0	Cardiac arrhythmias; decreased cardiac output
	85.2	29.0	Unconsciousness
Severe hypothermia	82.4	28.0	Ventricular fibrillation likely; hypoventilation
	80.6	27.0	Loss of reflexes and voluntary motion
	78.8	26.0	Acid-base disturbances; no response to pain
	11.0	25.0	Reduced cerebral blood flow
	15.2	24.0	Hypotension; bradycardia; pulmonary edema
	73.4	23.0	No corneal reflexes; areflexia
	66.2	19.0	Electroencephalographic silence
	64.4	18.0	Asystole
	59.2	15.2	Lowest infant survival from accidental hypothermia
	56.7	13.7	Lowest adult survival from accidental hypothermia

Source: US Department of the Army.[1]

that an average person can be immersed based on the water temperature and depth. This guidance is based on wearing normal personal protection that is not waterproof. It should also be noted that another type of cold injury—nonfreezing cold injury—can occur when skin is subjected to prolonged immersion or cold-wet exposures in temperatures between 32°F–60°F (0–15°C).

Risk factors for hypothermia include inactivity, energy depletion, endocrine disorders, age (old and young), burns and skin disorders, trauma, neuropathies, and drug/alcohol use.

Field expedient re-warming methods include removing wet clothes, increasing insulation (with dry clothes, blankets, sleeping bags), and moving to a sheltered area. If able to, patients can also exercise to increase heat production. Other techniques, using external re-warming, should be initiated by trained medical personnel.

Frostbite Prevention

Frostbite occurs when tissue temperature decreases below 32°F (0°C). Frostbite is most common in exposed skin (nose, ears, cheeks, exposed wrists), but also occurs in the hands and feet because peripheral vasoconstriction significantly lowers tissue temperatures. Wet skin cools faster. Instantaneous frostbite can occur when the skin comes in contact with super-cooled liquids, such as petroleum products, oil, fuel, antifreeze, and alcohol, all of which remain liquid at temperatures of -40°F (-40°C). Contact frostbite can occur by touching cold objects with bare skin (particularly highly conductive metal or stone), which causes rapid heat loss. To prevent contact frostbite, the workers should wear anti-contact gloves.

Usually, the first sign of frostbite is numbness. In the periphery, the initial sense of cooling begins at skin temperatures of 82°F (28°C) and pain appears at ~68°F (20°C), but as skin temperature falls below 50°F (10°C), these sensations are replaced by numbness. Individuals often report feeling a “wooden” sensation in the injured area. After re-warming, pain is significant. The initial sensations are an uncomfortable sense of cold, which may include tingling, burning, aching, sharp pain, and decreased sensation. The skin color may initially appear red; it then becomes waxy white.

Risk factors for frostbite include temperature, wetness, wind chill, constrictive clothing, race, sex, hypoxia, Raynaud syndrome, and vasoconstrictor drugs. African American men and women are 2–4 times more likely than Caucasians to suffer from frostbite. Raynaud disease is a peripheral vascular disorder more prevalent in women than men.

The Wind Chill Temperature (WCT) Index (Tables 4, 5) integrates wind speed and air temperature to provide an estimate of the cooling power of the environment. The WCT standardizes the cooling power of the environment to an equivalent air temperature for calm conditions. WCTs are specific in their correct application, only estimating the danger of cooling for the exposed skin of persons walking at 3 mph. Wind does not cause an exposed object to become cooler than the ambient temperature, but instead wind causes exposed objects to cool toward ambient temperature more rapidly than without wind. Wind speeds obtained from weather reports do not take into account man-made wind. The WCT presents the relative risk of frostbite and the predicted times to freezing (Tables 4 and 5) of exposed facial skin. Facial

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TABLE 2. Intensity of Exercise for Selected Outdoor Activities

Sedentary 100 Watts (1 MET)	Easy Work 250 Watts (2-3 METS)	Moderate Work 450 Watts (4-5 METS)	Hard Work 600 Watts (6 METS)
• Sleeping	• Walking (on level surface) at 3-4 km/h	• Walking in loose snow/sand at 2.5 mph, no load	• Walking on hard surface at 3.5 mph, 40-lb load
• Seated, quiet	• Snowmobiling	• Walking on hard surface at 3.5 mph, <40-lb load	• Walking in loose sand at 2.5 mph with load
		• Handling 50-kg bags	• Snowshoeing
		• Pick and shovel work	

Source: US Department of the Army.[1]

TABLE 3. Cold-Water Immersion Time Limits (Hours) for Reaching a Core Temperature of 35.5°C at Different Water Temperatures and Immersion Depths. For Immersion Times Greater than 6 Hours, the Risk of Nonfreezing Cold Injury Substantially Increases

Water Temperature (°F)	Water Temperature (°C)	Knee-Deep	Waist-Deep	Chest-Deep
50-54	10-12	12.8	1.9	1.3
55-59	13-15	15.6	7.5	2.2
60-64	16-18	22.2	10.2	7.9
65-69	18-21	33	13.8	10.5

Source: US Department of the Army.[1]

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TABLE 4. Wind Chill Temperature Index. Frostbite Times are for Exposed Facial Skin

Air Temperature (°C)

Wind Speed (km/h)	5	0	-5	-10	-15	-20	-25	-30	-35	-40	-45	-50
5	4	-2	-7	-13	-19	-24	-30	-36	-41	-47	-53	-58
10	3	-3	-9	-15	-21	-27	-33	-39	-45	-51	-57	-63
15	2	-4	-11	-17	-23	-29	-35	-41	-48	-54	-60	-66
20	1	-5	-12	-18	-24	-30	-37	-43	-49	-56	-62	-68
25	1	-6	-12	-19	-25	-32	-38	-44	-51	-57	-64	-70
30	0	-6	-13	-20	-26	-33	-39	-46	-52	-59	-65	-72
35	0	-7	-14	-20	-27	-33	-40	-47	-53	-60	-66	-73
40	-1	-7	-14	-21	-27	-34	-41	-48	-54	-61	-68	-74
45	-1	-8	-15	-21	-28	-35	-42	-48	-55	-62	-69	-75
50	-1	-8	-15	-22	-29	-35	-42	-49	-56	-63	-69	-76
55	-2	-8	-15	-22	-29	-36	-43	-50	-57	-63	-70	-77
60	-2	-9	-16	-23	-30	-36	-43	-50	-57	-64	-71	-78
65	-2	-9	-16	-23	-30	-37	-44	-51	-58	-65	-72	-79
70	-2	-9	-16	-23	-30	-37	-44	-51	-58	-65	-72	-80
75	-3	-10	-17	-24	-31	-38	-45	-52	-59	-66	-73	-80
80	-3	-10	-17	-24	-31	-38	-45	-52	-60	-67	-74	-81

FROSTBITE GUIDE

Low risk of frostbite for most people

Increasing risk of frostbite for most people in 10 to 30 minutes of exposure

High risk for most people in 5 to 10 minutes of exposure

High risk for most people in 2 to 5 minutes of exposure

High risk for most people in 2 minutes of exposure or less

Sources: Castellani et al.,[2] National Weather Service.[3]

skin was chosen because this area of the body is typically not protected. Frostbite cannot occur if the air temperature is above 32°F (0°C). Wet skin exposed to the wind will cool even faster and if the skin is wet and exposed to wind, the ambient temperature used for the WCT table should be 10°C (50°F) lower than the actual ambient temperature. When cold surfaces below -7°C (19.4°F) are within reach, a warning should be given to each worker by the supervisor to prevent inadvertent contact by bare skin. If the air temperature is -17.5°C (0°F) or less, the hands should be protected by mittens. Machine controls and tools for use in cold conditions should be designed so that they can be handled without removing the mittens.

Manual dexterity is an important attribute in occupational settings. Manual dexterity is the ability to make coordinated hand and finger movements to grasp and manipulate objects. Manual dexterity includes muscular, skeletal, and neurological functions to produce small, precise movements. In cold weather, manual dexterity can decrease 60% to 80% in gloved workers and, depending on the ambient conditions, can decrease just as much in nongloved personnel. When hand temperature declines, the manual performance deteriorates. This performance is reduced by 30% when the finger skin temperature decreases from 33°C (91°F) to 10°C (50°F). Special protection of the hands is required to maintain manual dexterity for the prevention of accidents:

TABLE 5. Time in Minutes Until the Occurrence of Cheek Frostbite in the Most Susceptible 5% of Military Personnel

Wind speed		Air temperature											
$m \cdot s^{-1}$	mph	°C	−12	−15	−18	−21	−23	−26	−29	−32	−34	−37	−40	−43
		°F	10	5	0	−5	−10	−15	−20	−25	−30	−35	−40	−45
2	5		>120	>120	>120	>120	31	22	17	14	12	11	9	8
4	10		>120	>120	>120	28	19	15	12	10	9	7	7	6
7	15		>120	>120	33	20	15	12	9	8	7	6	5	4
9	20		>120	>120	23	16	12	9	8	8	6	5	4	4
11	25		>120	42	19	13	10	8	7	6	5	4	4	3
13	30		>120	28	16	12	9	7	6	5	4	4	3	3
16	35		>120	23	14	10	8	6	5	4	4	3	3	2
18	40		>120	20	13	9	7	6	5	4	3	3	2	2
20	45		>120	18	12	8	7	5	4	4	3	3	2	2
22	50		>120	16	11	8	6	5	4	3	3	2	2	2

Note: Wet skin could significantly decrease the time for frostbite to occur.

FROSTBITE RISK

LOW – freezing is possible, but unlikely (WHITE)

HIGH – freezing could occur in 10–30 minutes (LIGHT GREY)

SEVERE – freezing could occur in 5–10 minutes (DARK GREY)

EXTREME – freezing could occur in < 5 minutes (MEDIUM GREY)

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1. If fine work is to be performed with bare hands for more than 10–20 minutes in an environment below 16°C (60.8°F), special provisions should be established for keeping the worker's hands warm. For this purpose, warm air jets, radiant heaters (fuel burner or electric radiator), or contact warm plates may be utilized. Metal handles of tools and control bars should be covered by thermal insulating material at temperatures below -1°C (30.2°F).
2. If the air temperature falls below 16°C (60.8°F) for sedentary work, 4°C (39.2°F) for light work, and -7°C (19.4°F) for moderate work and fine manual dexterity is not required, then gloves should be used by the workers.

Dexterity is primarily impacted by peripheral skin and muscle temperatures, with little influence from core temperature.

Acute Cold-Water Exposure

Sudden immersion into cold water causes a cold shock response. Physiological responses to sudden immersion include gasping, hyperventilating, peripheral vasoconstriction, and increased heart rate and blood pressure. It is during the first few minutes of sudden immersion that drowning is likely to occur as gasping and hyperventilating increase the chances of aspirating water. After the initial responses subside, the core and muscle temperatures begin to fall over time. After ~10 minutes of immersion in water less than 10°C, muscle temperatures will have decreased so that there is reduced skeletal muscle function. Individuals at this point will no longer be able to swim/self-rescue and drowning will likely ensue if a flotation aid is not available. Finally, as an individual remains in the water, core temperature will continue to fall. Generally, the core temperature falls to 35°C in about 1 hour in 5°C water, in 2 hours in 10°C water, and in 3 to 6 hours in 15°C water. The progression from cold shock to hypothermia can be summed up in the "1-10-1" rule. This states that the cold shock response with increased water aspiration occurs in the first minute; in 10 minutes the skeletal muscle temperatures decline to a point that muscle function is severely impaired, and in 1 hour, core temperature begins to fall to levels that are dangerous.

Cold-Weather Clothing

Cold-weather clothing protects against hypothermia and peripheral cold injuries by reducing heat loss through the insulation provided by the clothing and the trapped air within and between clothing layers. Typical cold-weather clothing consists of multiple layers: an inner layer (light-weight polyester or polypropylene) that is in direct contact with the skin and does not readily absorb moisture, but wicks moisture to the outer layers where it can evaporate; middle layers (polyester fleece or wool) provide the primary insulation; and an outer layer, which is designed to allow moisture transfer to the air, while repelling wind and rain. Sweating can easily exceed the vapor transfer rate of the outer shell layer, causing moisture to accumulate on the inside, even if the outer layer has substantial venting (e.g., zippers in armpits) to allow moisture to escape. The outer layer should typically not be worn during moderate/heavy work (unless it is rainy or very windy), but should be donned during subsequent rest periods.

Imposing a single standard clothing ensemble for an entire group could result in overheating and sweating during work in some, while others would not be kept warm; therefore, people should adjust clothing according to their own needs. A common problem is that people begin working while still wearing clothing layers appropriate for resting conditions, and thus, are "overdressed" after the work is started. If the combination of environmental conditions, work intensity, and available clothing suggest that body heat content cannot be maintained (e.g., low work intensity in rainy conditions), then supervision of the worker or use of the buddy system should be encouraged. All workers need to be aware that the risk of hypothermia increases if the weather is wet and wet-weather clothing is not available and work intensity is low (e.g., stop digging to rest). Remaining dry, especially for those working in remote regions, is extremely important and dictates that carrying extra clothing that is water-proof and dry clothing to change into is vital. If work is done at normal temperatures or in a hot environment before entering the cold area, the employee should make sure that clothing is not wet as a consequence of sweating. If clothing is wet, the employee should change into dry clothes before entering the cold area. The workers should change socks and any removable felt insoles at regular, daily intervals or use vapor barrier boots. The optimal frequency of change should be determined empirically and will vary individually and according to the type of shoe worn and how much the individual's feet sweat.

If exposed areas of the body cannot be protected sufficiently to prevent sensation of excessive cold or frostbite, protective items should be supplied in auxiliary heated versions.

If the available clothing does not give adequate protection to prevent hypothermia or frostbite, work should be modified or suspended until adequate clothing is made available or until weather conditions improve. Feet are susceptible to peripheral cold injuries. All workers should be provided with appropriately rated footwear for the conditions they are working in. For example, if the environment is wet, footwear should provide protection against water penetration; likewise, if the air temperatures have the potential to be extremely low (less than 0°F (-18°C)), specific boots for this environment need to be provided.

Work-Warming Regimen

If work is performed continuously in the cold at or below a WCT of -7°C (19.4°F), heated warming shelters (tents, cabins, rest rooms, etc.) should be made available nearby. The workers should be encouraged to use these shelters at regular intervals, the frequency depending on the severity of the environmental exposure. Indications for immediate return to the shelter are the onset of heavy shivering; frostnip; or the feeling of excessive fatigue, drowsiness, irritability, or euphoria. When entering the heated shelter, the outer layer of clothing should be removed and the remainder of the clothing loosened to permit sweat evaporation, or a change of dry work clothing should be provided as necessary to prevent workers from returning to their work with wet clothing. Dehydration, or the loss of body fluids, occurs insidiously in the cold environment and can impair work performance. However, dehydration likely does not increase susceptibility to cold injuries. Workers

can drink a variety of fluids (milk, juice, sports drinks, tea, coffee). Hot beverages and soups should be provided at the work site as they provide calories and increase morale.

For work at or below -12°C (10.4°F) WCT, the following should apply:

1. The worker should be under constant protective observation (buddy system or supervision).
2. The work rate should not be so high as to cause heavy sweating that will result in wet clothing; if heavy work must be done, rest periods should be taken in heated shelters and opportunity for changing into dry clothing should be provided.
3. New employees should not be required to work full-time in the cold during the first days of employment until they become accustomed to the working conditions and required protective clothing.
4. The weight and bulkiness of clothing should be included in estimating the required work performance and weights to be lifted by the worker.
5. The work should be arranged in such a way that sitting still or standing still for long periods is minimized. Unprotected, metal chair seats should not be used. The worker should be protected from drafts to the greatest extent possible.
6. The worker should be instructed in safety and health procedures. The training program should include, as a minimum, instruction in:
   A. Proper re-warming procedures and appropriate first aid treatment.
   B. Proper clothing practices.
   C. Proper eating and drinking habits.
   D. Recognition of impending frostbite.
   E. Recognition of signs and symptoms of impending hypothermia or excessive cooling of the body even when shivering does not occur.
   F. Safe work practices.

Special Workplace Recommendations

Special design requirements for refrigerator rooms include:

1. Air velocity should be minimized as much as possible and should not exceed 1 m/sec (200 fpm) at the job site. This can be achieved by properly designed air distribution systems.
2. Special wind protective clothing should be provided based on existing air velocities to which workers are exposed.

Special caution should be exercised when working with toxic substances and when workers are exposed to vibration. Cold exposure may require reduced exposure limits.

Eye protection for workers employed out-of-doors in a snow- and/or ice-covered terrain should be supplied. Special safety goggles to protect against ultraviolet light and glare (which can produce temporary conjunctivitis and/or temporary loss of vision) and blowing ice crystals should be required when there is an expanse of snow coverage causing a potential eye exposure hazard.

Workplace monitoring is required as follows:

1. Suitable thermometry should be arranged at any workplace where the environmental temperature is below 16°C (60.8°F) so that overall compliance with the requirements of the TLV can be maintained.
2. Whenever the air temperature at a workplace falls below -1°C (30.2°F), the air temperature should be measured and recorded at least every 4 hours.
3. In indoor workplaces, the wind speed should also be recorded at least every 4 hours whenever the rate of air movement exceeds 2 m/sec (5 mph).
4. In outdoor work situations, the wind speed should be measured and recorded together with the air temperature whenever the air temperature is below -1°C (30.2°F).
5. The WCT should be obtained from Table 4 in all cases where air movement measurements are required; it should be recorded with the other data whenever the WCT is below -7°C (19.4°F).

Employees should be excluded from work in cold at -1°C (30.2°F) or below if they are suffering from diseases or taking medication that interferes with normal body temperature regulation or reduces tolerance to work in cold environments. Workers who are routinely exposed to temperatures below -24°C (-11.2°F) with wind speeds <2 m/sec (5 mph), or air temperatures below -18°C (0°F) with wind speeds above 2 m/sec (5 mph), should be medically certified as suitable for such exposures.

Trauma sustained in freezing or subzero conditions requires special attention because an injured worker is predisposed to cold injury. In addition to providing for first aid treatment, special provisions should be made to prevent hypothermia and freezing of damaged tissues.

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Selected Reading

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HEAT STRESS AND STRAIN
(Documentation Date – 2022)

Warning: The TLV is based on the ability of most healthy hydrated acclimatized workers to sustain thermal equilibrium. The action limit (AL) is similarly prescribed for healthy hydrated unacclimatized workers. This TLV has a small margin of safety, and some workers may experience heat-related disorders below the TLV or AL.

Introduction: The goal of the TLV is to limit heat stress exposures to those that may be sustained for hours; that is, where healthy acclimatized individuals can achieve and maintain thermal equilibrium. The AL describes conditions where most healthy unacclimatized workers can achieve thermal equilibrium. If thermal equilibrium cannot be sustained, there is an increasing likelihood of heat exhaustion or heat stroke. While not considered for the TLV, there is also an increased likelihood of errors in judgement, acute injury, and adverse incidents with increasing heat stress. Furthermore, the TLV assumes complete recovery from a previous heat stress exposure.

The TLV is represented in Figure 1 by the solid line, and the Action Limit is represented by the broken line. The Wet Bulb Globe Temperature (WBGT) incorporates the environmental factors of air temperature, humidity, air movement, and radiant heat. WBGTeff is the measured WBGT plus the clothing adjustment value (CAV). The task Metabolic Rate (M) measured in Watts [W] is the energy expenditure.

For computational purposes, the TLV and AL are calculated with the following:

$$\text{TLV}[^\circ\text{C}] = 56.7 - 11.5 \log_{10}\text{M}[\text{W}] \quad \textbf{(1)}$$

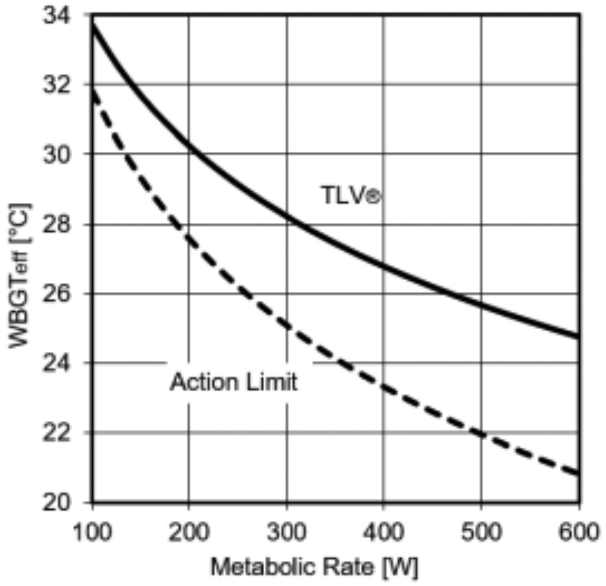
$$\text{AL}[^\circ\text{C}] = 60.0 - 14.1 \log_{10}\text{M}[\text{W}] \quad \textbf{(2)}$$

Heat Stress is the net heat load to which a worker may be exposed from the combined effects of metabolic heat, environmental factors, and clothing requirements. As heat stress increases and approaches the upper limit of heat tolerance, further increases may lead to unacceptable heat strain and the possibility of heat-related disorders.

Heat Strain is the overall physiological response resulting from heat stress. Normal physiological responses are dedicated to dissipating excess heat from the body. When these normal responses are no longer adequate, excessive heat strain may result.

Metabolic Rate is the energy expenditure associated with work activities, and this expenditure generates internal heat that must be dissipated by the body. The metabolic rate due to work is as important as the WBGT assessment in evaluating heat stress. ISO8996 provides recognized methods to assess metabolic rate.[1] While energy expenditure is best measured by oxygen consumption, various methods of estimation are available. Assignment of a category is among the least accurate methods but relatively easy to use. Table 1 provides useful categories of metabolic heat generation.

FIGURE 1. TLV and Action Level for Heat Stress



The TLV uses the WBGT (as defined above) index to estimate the environmental contributions to heat stress.[2] WBGT uses air or dry-bulb temperature (T_{db}), natural wet-bulb temperature (T_{nwb}) and globe temperature (T_g). The determination of WBGT depends on whether it is measured in direct sun ($WBGT_{out/sun}$) or in shaded or indoor conditions ($WBGTi_{n/shade}$) as follows:

$$WBGT_{out/sun} = 0.7\ T_{nwb} + 0.2\ T_g + 0.1\ T_{db} \quad \textbf{(3)}$$

$$WBGTi_{n/shade} = 0.7\ T_{nwb} + 0.3\ T_g. \quad \textbf{(4)}$$

$WBGT_{eff}$ is the *effective* WBGT, which is the WBGT adjusted for clothing. Clothing affects the ability to dissipate internal heat to the ambient environment. To account for the effects of clothing, Clothing Adjustment Values (CAVs) are provided in Table 2 for some clothing configurations. The CAVs are expressed as equivalent values of WBGT that are added to the ambient WBGT to yield an effective WBGT ($WBGT_{eff}$).

Time-Weighted Averaging (TWA) of 1 hour can be used to assess changing heat stress exposures. TWAs of greater than an hour may result in unacceptable exposures.

Acclimatization is a physiological adaptation that improves an individual's ability to tolerate heat stress. Acclimatization requires physical activity under heat stress conditions like those anticipated for the work. With a recent history of heat stress exposures of at least 2 continuous hours for 5 of the last 7 days, a worker may be considered acclimatized for the purposes of the TLV. Acclimatization declines when activity under heat stress conditions is discontinued. A noticeable loss occurs after 4 days and may be completely lost in 3 weeks. A person may not be fully acclimatized to a sudden or episodic higher level of heat stress.

TABLE 1. Metabolic Rate Categories and the Representative Metabolic Rate with Example Activities

Category	Assigned Metabolic Rate (W)	Examples
Rest	115	Sitting
Light 115-235 W	180	Sitting with light manual work with hands or hands and arms and driving. Standing, with some light arm work and occasional walking.
Moderate 235-360 W	300	Sustained moderate hand and arm work, moderate arm and leg work, moderate arm and trunk work, or light pushing and pulling. Normal walking.
Heavy 360-470 W	415	Intense arm and trunk work, carrying, shoveling, manual sawing; pushing and pulling heavy loads; and walking at a fast pace.
Very heavy >470 W	520	Very intense activity at fast to maximum pace.

Note: The effect of body weight on the estimated metabolic rate can be accounted for by multiply ing the estimated rate by the ratio of actual body weight divided by 70 kg (154 lb).
Source: International Organization for Standardization, 2017.

A Heat Stress Management Program (HSMP) sets workplace policy and includes written plans for training, heat stress hygiene practices, surveillance, physiological monitoring, recordkeeping, and an emergency plan. Triggers for and components of an HSMP are presented below.

General Controls in an HSMP are those actions to protect workers that apply when heat stress is expected to be a hazard. They apply broadly to workplaces and exposure conditions. General Controls include training, heat stress hygiene practices, environmental surveillance, policies on acclimatization, policies on recognizing heat-related symptoms and first aid, and emergency planning.

Job Specific Controls in an HSMP are those actions that may be taken to control heat stress during particular heat stress exposure conditions. Job Specific Controls can be used to reduce the heat stress level to acceptable levels and include the traditional hierarchy of engineering controls, administrative controls, and personal cooling. After implementing Job Specific Controls, it is necessary to continue to assess their effectiveness and to make adjustments as needed.

Evaluation Process: The evaluation process should be started if heat stress is expected, for example, if: (1) there are reports of discomfort or other symp-

TABLE 2. Clothing Adjustment Values (CAV) added to WBGT to estimate $WBGT_{eff}$

Clothing Type	CAV (°C)
Short sleeves and pants of woven material	−1 .0
Work clothes (long sleeve shirt and pants)	0
Cloth (woven material) coveralls	0
SMS polypropylene coveralls	0.5
Polyolefin coveralls	1
Double-layer woven clothing	3
Limited-use vapor-barrier coveralls with Hood	11
Adding a hood (full head and neck covering; not face)	+1.0

Notes:

1. These values must not be used for completely encapsulating suits, often called Level A as defined by OSHA.

2. CAVs cannot be added for multiple layers.

3. Coveralls assume that only undergarments are worn underneath, not a second layer of clothing.

4. There is no evidence to suggest that respirators or face coverings add to the heat stress burden .

toms associated with heat stress; (2) professional judgment indicates heat stress conditions; or (3) the Heat Index or air temperature is 27ºC (80ºF). When heat stress is suspected, establishing an HSMP that includes the General Controls (see Table 5) is recommended.

Four methods to evaluate the level of heat stress, with increasing levels of complexity and increasing levels of professional expertise, are presented below. The TLV and AL is represented by Method 2.

Method 1: Screening Criteria Based on $WBGT_{eff}$. This screening criteria are an approximation of the TLV and AL as presented in Figure 1. Screening criteria for heat stress exposure considers the contributions of environment, metabolic work demands, work-rest pattern, clothing, and acclimatization state. Table 3 provides the screening criteria.

If the estimated TWA-$WBGT_{eff}$ is less than the criteria for unacclimatized workers found in Table 3, then there is little risk of excessive exposures to heat stress.

If the estimated TWA-$WBGT_{eff}$ are above the criteria for unacclimatized workers found in Table 3, but below the limits for acclimatized workers, then an HSMP that includes the General Controls in Table 5 is recommended.

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TABLE 3. Screening Criteria using $WBGT_{eff}$ (°C) for Acclimatized and Unacclimatized Workers

Allocation of Work in a Heavy Cycle of Work and Recovery	Metabolic Rate for Acclimatized Workers				Metabolic Rate for Unacclimatized Workers			
	Light	Moderate	Heavy	Very Heavy	Light	Moderate	Heavy	Very Heavy
75%-100%	31.0	28 0	—	—	28.0	25.0	—	—
50%-75%	31.0	29.0	27.5	—	28.5	26.0	24.0	—
25%-50%	32.0	30.0	29.0	28.0	29.5	27.0	25.5	24.5
0-25%	32.5	31.5	30.5	30.0	30.0	29.0	28.0	27.0

Notes:

1. See Table I for metabolic work demand categories.
2. The thresholds are computed as a TWA metabolic rate where the metabolic rate for rest is taken as 115 W and work is the representative (midrange) value of Table 1. The time base is taken as the proportion of work at the upper limit of the percent work range (e.g., 50% for the range of 25%-50%).
3. WBGT values are expressed to the nearest 0.5°C.
4. If work and rest environments are different or work and rest are distributed over more than 1 location, hourly time-weighted averages (TWA) WBGT should be calculated and used. TWAs for work rates should also be used when the work demands vary within the hour. Note that the metabolic rate for rest is already factored into the screening limit.
5. Values in the table assume 8-hour workdays in a 5-day workweek with conventional breaks.
6. Because the physiological strain associated with Heavy and Very Heavy work among less fit workers regardless of WBGT may be unsustainable, screening criteria values are not provided for near continuous work and for up to 25% rest in an hour for Very Heavy. The screening criteria are not recommended, instead a TWA analysis and/or physiological monitoring should be used.
7. Table 3 is intended as an initial screening tool to evaluate whether a heat stress situation may exist and thus the table is more protective than the TLV or AL. Because the values are more protective, they are not intended to prescribe work and recovery periods.

TABLE 4. Guidelines for Physiologic Monitoring of Heat Strain

Monitoring heat strain and signs and symptoms of heat-related disorders is sound industrial hygiene practice, especially when clothing may significantly reduce heat loss. When monitoring for safety, exceeding these guidelines indicates a need to better control exposures. When monitoring individuals, excessive heat strain indicates a time to cease an exposure and allow for recovery. One or more of the following measures may indicate excessive heat strain, and an individual's exposure to heat stress should be discontinued when any of the following occur:

- Sustained (several minutes) heart rate is in excess of 180 beats per minute (bpm) minus the individual's age in years (180 − age), for healthy individuals with normal cardiac response.
- Measured or estimated core temperature increases by more than 1°C from pre–job temperature if the pre–job temperature is less than 37.5°C.
- Recovery heart rate at 1 minute after a peak work effort is greater than 120 bpm.
- Exposure should stop with signs or symptoms of heat exhaustion or heat stroke or with a request to stop regardless of what physiological monitoring may indicate.

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If there are observed signs or reports of symptoms of heat-related disorders, such as fatigue, nausea, dizziness, and lightheadedness, then establishing an HSMP with General Controls is recommended.

Method 2: TLV Analysis. Method 1 (Table 3) is a screening step that requires less effort than a full evaluation. The actual TLV and AL are based on the TWAs of $WBGT_{eff}$ and task metabolic rate (M). A task analysis is used to compute TWAs for $WBGT_{eff}$ and M. The TWA window should capture at least 1 cycle of work and recovery period within a 1-hour period. The values of TWA-$WBGT_{eff}$ and TWA-M are compared to the TLV and AL lines in Figure 1.

If the exposure is below the AL, the heat stress exposure is acceptable. While no further action is necessary, consider establishing an HSMP that includes General Controls (see Table 5).

If the TWA analysis indicates an exposure between the AL and TLV, then an HSMP that includes General Controls (see Table 5) is recommended.

If the exposure is above the TLV, then an HSMP with General and Job Specific Controls (see Table 5) is recommended to bring the exposure below the TLV or acceptable limits.

Method 3: Advanced Heat Stress Evaluation. Advanced methods for evaluating heat stress consider a time limit or greater detail in understanding the major contributors to the heat stress exposure. Two methods with extensive use and verification are the Predicted Heat Strain (PHS)[3] and the US Army Heat Stress Decision Aid (HSDA).[4]

TLV–PA

Regardless of the outcome of the analysis, an HSMP is recommended. These alternative methods may also provide insight into Job Specific Controls (see Table 5) that would reduce the risk of heat-related disorders.

Method 4: Heat Strain and Physiologic Monitoring. The likelihood and severity of excessive heat strain will vary widely among people, even under identical heat stress conditions. The normal physiological responses to heat stress provide an opportunity to monitor heat strain among workers and to use this information to assess the level of heat strain present in the workforce, to control exposures, and to assess the effectiveness of implemented controls. There are various approaches to monitoring heat strain. These include core temperature (e.g., using ingestible temperature pills or time series heart rate-derived core temperature), tympanic temperature, skin temperature, and heat strain indices (e.g., heart rate and core temperature).

Table 4 provides guidance for acceptable levels of heat strain when using physiologic monitoring. However, the values should not be considered as TLVs. If excessive heat strain occurs, then appropriate Job Specific Controls (see Table 5) should be implemented to a sufficient extent to control the heat strain, to bring the exposure level below the TLV, or to a level that is acceptable by an advanced method. Professional judgement is necessary to select the appropriate frequency and methodology of physiological monitoring considering the magnitude of the heat stress expected.

Heat Stress Management Program. The elements of a written heat stress management program include at least General Controls and include Job Specific Controls when there is a possibility of exposures greater than the TLV

TABLE 5. Elements of a Heat Stress Management Program

General controls are essential elements of an HSMP. Job-specific controls are added as appropriate.
General Controls
• Training: Provide verbal and written instructions for pre–job and annual training programs with information about heat stress and strain, heat disorders, mitigation plan, and emergency response plan in a language and format that is understood by workers and supervisors.
• Heat Stress Hygiene Practices: Fluid replacement, self-monitoring of symptoms, maintain good health status, appropriate breaks with shade, and modify expectations based on acclimatization.
• Policies: Acclimatization plan, early recognition of heat-related signs and symptoms in other workers and actions to take, and on self-determination.
• Environmental surveillance.
• Medical clearance and counseling by a healthcare provider.
• Emergency Response Plan: The worker who appears to be confused, disoriented, irritable, or has malaise, chills, or seizures should be managed as a medical emergency and needs aggressive cooling, emergency transport, and continuous observation.
Job-Specific Controls
• Engineering controls that reduce the metabolic rate, provide general air movement, reduce process heat and water vapor release, provide shade, shield radiant heat sources, and adjust clothing requirements, among others.
• Administrative controls that set acceptable exposure times, allow sufficient recovery, and limit physiological strain.
• Personal cooling (air, liquid, ice) that is effective for the specific work practices and conditions.
• Physiological monitoring.

or AL or indicated by an alternative method of evaluation. Table 5 lists some key elements of a HSMP.

The principal objective of a HSMP is the prevention of excessive heat strain among workers that may result in heat-related disorders. A HSMP sets policy and includes written plans for training, heat stress hygiene practices, surveillance, physiological monitoring, recordkeeping, and an emergency plan.

The trainings in the HSMP should discuss acclimatization and warn: (1) workers to be alert to unexpected fatigue, dizziness, lightheadedness, nausea, and headache; and (2) coworkers and supervisors to be alert to other workers for signs of heat-related disorders such as confusion, agitation, irritability, delirium, seizures, loss of consciousness, and physiological monitoring measures that mark excessive heat strain. The HSMP should remind workers with personal risk factors that may lower tolerance to heat stress that they may be at greater risk for heat-related disorders. Lower tolerance is associated with: (1) a prior history of heat stroke or episodes of heat exhaustion; (2) health conditions or medications that affect the cardiovascular system, water and electrolyte balance, metabolism, or thermoregulation; (3) acclimatization state; and (4) lower aerobic capacity, obesity, pregnancy, or age.

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2023 PHYSICAL AGENTS AND OTHER ISSUES UNDER STUDY

The TLV Physical Agents Committee solicits information, especially data, which may assist it in its deliberations regarding the following agents and issues. Comments and suggestions, accompanied by substantiating evidence, preferably in the form of peer-reviewed literature, should be forwarded in electronic format to the ACGIH Science Group at science@acgih.org. In addition, the Committee solicits recommendations for additional agents and issues of concern to the industrial hygiene and occupational health communities. Please refer to the ACGIH TLV/BEI Development Process found on the ACGIH website for a detailed discussion covering this procedure and methods for input to ACGIH (acgih.org/science/tlv-bei-guidelines/policies-procedures-presentations/tlv-bei-development/).

The Under Study list is published on the ACGIH website (acgih.org/tlv-bei-guidelines/documentation-publications-and-data/under-study-list) and later in the TLVs and BEIs book.

The agents and issues listed below are current as of December 1, 2023. After this date, please refer to the ACGIH website (acgih.org/science/tlv-bei-guidelines/documentation-publications-and-data/under-study) for the up-to-date list.

Physical Agents

Electromagnetic Fields
Ergonomics
- Hand-Arm Vibration

Other Issues Under Study

Appendix C: Statement on Fatigue and its Management in the Workplace
Generalized Fatigue and Work Schedules
Hyperbaric Pressure
Hypobaric Pressure
Introduction to the Physical Agents

APPENDIX A: STATEMENT ON THE OCCUPATIONAL HEALTH ASPECTS OF NEW LIGHTING TECHNOLOGIES – CIRCADIAN, NEUROENDOCRINE, AND NEUROBEHAVIORAL EFFECTS OF LIGHT

Over the past decade a revolution in indoor lighting has been underway, fueled partly by new technologies of compact fluorescent lamps (CFLs) and solid-state, light-emitting-diode (LED) lamps, and partly by efforts to reduce the consumption of electrical energy. Do these changes in the work environment pose any real health concerns? The ACGIH TLV for Light and Near Infrared Radiation for evaluating optical radiation have existed for decades and lamp-safety standards refer to these TLVs. These are designed chiefly to avoid retinal injuries from exposure to very intense light sources (e.g., welding arcs). In most workplace settings, there is little to no chance that workers will be exposed to general lighting sources (GLS) used for visual purposes that exceed current TLV.

However, the new lighting technologies, in particular LED and CFL lighting that are now widely used in workplaces for energy conservation, have significantly different spectral output than traditional incandescent light bulbs. There is considerable evidence that the body is highly sensitive to the blue light that forms a considerable fraction of the output of these sources. Some of the new lamps have sufficiently different spectra (color spectra) that concerns have been raised about potential health effects.[1-3] This Statement addresses possible health and safety issues that are associated with artificial lighting at levels that would be used for visual purposes.

Light is a potent stimulus for regulating circadian, hormonal, and behavioral systems in humans. Research over the past 12 years has shown that the biological and behavioral effects of light are particularly influenced by a distinct photoreceptor in the eye, the melanopsin containing intrinsically photosensitive retinal ganglion cells (ipRGCs), in addition to the conventional rods and cones.[3-5] Published action spectra show that ipRGCs are most sensitive to blue-appearing light with a strong sensitivity in the 450- to 520-nm spectral band for circadian, neuroendocrine and neurobehavioral regulation in humans (480 nm is widely cited when a single peak is provided). However, the relatively recent discovery of a new photopigment (melanopsin) in the retina located in a previously unknown photoreceptor,[6,7] referred to as the "intrinsically photoreceptive retinal ganglion cell" (ipRGC), has raised new questions regarding light and health.[2] The ipRGC responds strongly to short-wavelength (blue) light and plays a key role in neurobiological and neurobehavioral effects that fall under the general umbrella of "circadian" effects.[4,8] The circadian (24-h) rhythm affects many physiological processes in the body other than just the sleep/wake cycle. Most organ systems undergo circadian cycles regulated by the neuroendocrine system. These include circadian rhythms, variations in body temperature, heart rate, etc.[9] Variations in hormone levels beside melatonin include cortisol and thyroid stimulating hormone (TSH). Thus, the physiological processes that determine mood, performance, alertness and tiredness are affected. The adverse physiological effects of shift work are driven by circadian disruption.

Particular attention has been paid to the potential for blue light (460-490 nm) to increase alertness, since the blue-sensitive ipRGCs signal the pineal body (through the suprachiasmatic nucleus) to suppress secretion of melatonin (the

"sleep hormone"). Indeed, there have been suggestions to increase alertness in the workplace by increasing the blue light spectrum in office lighting. This is most often described in the lighting literature as increasing the correlated color temperature (CCT) of the lamp spectrum, although this is not the most accurate way to describe the 'melanopic' content of light, as different light spectra can have the same CCT.[4] In reality, all visible wavelengths provide an alerting stimulus during the day.

Some life scientists have noted that blue light is frequently cited as producing a phototoxic effect at very high retinal exposure levels, but far more than produced by standard commercially available general-service lamps. Although concerns have arisen as to the potential for adverse effects from chronic exposure to new lighting installations with blue-rich emissions in workplace lighting,[10] routine, normal exposure to the newer blue-rich lamps will remain well below the TLV for UV, visible and infrared radiation. General lighting service lamps for illumination also meet photobiological safety standards (based on the TLV). The IARC classification of shift work as a probable carcinogen has accentuated concerns that lighting in workplaces might play a role in carcinogenesis; however, this hypothesis remains quite controversial.[11]

Conclusions and Recommendations

Given the present state of knowledge, ACGIH considers that its present TLV are sufficiently protective against photochemically induced "blue light hazard." ACGIH does not consider it practical or advisable to develop TLV to protect against light-induced changes in circadian rhythms or possible related health effects from shift work.

However, employers and occupational safety experts are advised:

1. Shift work involves a range of issues apart from disruption of circadian rhythms, and these are best addressed by measures such as optimal planning of work schedules, rather than exposure limits such as TLV. Employers should be aware of recommendations by NIOSH and other occupational health organizations about shift work. For example: http://www.cdc.gov/niosh/topics/workschedules/.
2. Adjusting the color palette of computer displays to reduce their short-wavelength content or dimming computer screens for evening work has been shown to affect circadian physiology and cognitive performance.[12,13] Tools to adjust the color palette exist. The magnitude, if any, of any health benefit from their use remains unproven.
3. In occupational settings, employee alertness, safety and health are key. The lighting conditions should provide the safest and most alerting environment possible, while maintaining typical visual function. Work environments should therefore incorporate high intensity, blue-enriched (high melanopic) light during both the day, and especially at night given the high risk of sleepiness-related accidents and injuries. In occupational settings where there are potentially conflicting needs, such as a hospital during the night when patients sleep but staff are awake, the patient bedroom or ward environment should be optimized for sleep with low intensity, blue-depleted (low melanopic) light while the staff environment (nursing station, break rooms) should enhance alertness with high intensity, blue-enriched (high melanopic) light. During the daytime, both groups would benefit from high

intensity, blue-enriched (high melanopic) light. These more complex environments need careful consideration of the spectrum, location and use of the light but are likely to be solved through the lighting design process.

4. Worker complaints related to new installations of high-intensity, high-brightness LED lighting fixtures frequently relate to discomfort glare because of poor luminaire design or installation, not the blue-enriched spectrum of the light. Consulting good lighting practice guides may be helpful. For example: *IESNA Lighting Handbook*.[14]

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APPENDIX B: PERSONAL PHYSIOLOGIC MONITORING IN THE WORKPLACE

The development of recent technologies opens the possibility of continuously monitoring physiologic responses of workers for the assessment of health and safety factors. Specifically, the use of these systems could provide actionable information that guides the worker on safe and effective performance such as warning about approaching thermal-work strain limits, extremity freezing cold injury risk, hypoxia risks, impending muscle fatigue, injury, etc.[1] They may also be proposed as dosimeters for health risk exposures based on physiological responses and workload, and perhaps measured in conjunction with environmental sensors. A third major category of proposed use is to detect an injury event and trigger an automatic "911," assist with geolocation of the individual worker, and provide early medical triage assistance with signs and symptoms.

Workplace health and safety personnel may be called on to assess the value and use of these devices for protecting the health of workers. While there are some very specialized use cases for real time physiological monitoring today, there are few systems that have been fully validated for use.[2] Furthermore, there are systems that are available that may be dangerous because they provide inaccurate information, the technologies interfere with other systems, or the systems themselves provide some risks to the workers.

Physiological monitoring systems involve sensors along with some kind of data collection and transmission strategy and they require software algorithms and models that turn the sensor information into useful and actionable information. The interpretation of the signals is equally important to the quality of the measurements. Raw data such as heart rate, oxygen saturation, or skin temperature are not as useful to a worker or their supervisors as a stoplight system of alerts (e.g., green-amber-red warnings) that can be queried or outputs that recommend data-based work-rest cycles, etc. A number of factors should be evaluated before these devices are adopted for routine worker monitoring.

- Device design issues
  - Usability
  - Accuracy
  - Reliability
  - Safety
- Policy issues
  - Data analysis and interpretation
  - Ownership and control of information
  - Decision on workplace interventions
  - Discrimination
  - Security
  - Training

The device should be evaluated for accuracy against a gold standard across a range of the workplace settings where it would be expected to be used. Reliability should be evaluated across differences in expected users, environments, and settings. Usability should be evaluated by novice users to address design issues and training requirements. Current systems and systems in development suffer from size, weight, and power issues. Power is a particular problem for many of the continuous monitoring systems with high frequency data

capture and transmission, requiring frequent battery replacement or recharge.[3,4] Safety factors should be evaluated if decisions made using information from the device may impact worker safety or health. If medical decisions will be made from this information, the devices will require FDA certification.

Policy issues become important based on how the data are interpreted and the actions taken based on those interpretations. Information may be directly used by the worker to provide recommendations for actions they should take. Or information may be used by the employer for changes in work assignments, work restrictions, or changing work practices. In addition, there are increasing concerns about cybersecurity for seemingly trivial personal physiological data as well, both in terms of privacy and risk of interference with predictive outputs.[5]

Questions on who owns the data, where the data are stored, who has access to the data and how long the data are stored are important to employees and employers. Other concerns relate to distinguishing occupational health effects from personal medical data that can be derived from these measurements but are not related to the job; determination of what may be reported to insurers or medical records; and efforts to assess individual work performance and productivity.

Wearable technologies are evolving rapidly into wear-and-forget smart clothing systems and will soon be proposed as ubiquitous implantable systems such as the RFID personal identifier chips that are coming into use. Feasibility of body powered systems that do not require batteries has been demonstrated and these systems are currently in development, drawing power from body heat and movement. Individual systems will increase in usefulness as they learn their individual users with adaptive algorithms and as they are networked into the internet of things (IoT), gaining context from other systems in the surrounding environment.

Personal physiological measurements should reliably signal a relevant exposure or health outcome before they are adopted in the workplace. In addition, policy issues such as privacy, ownership, security, training and actions taken should be worked out in advance before workplace adoption. Personal physiological measurement technologies make it possible to move from generalized workplace assessments to personalized health status assessments of the individual worker. However, the measurements must benefit the health and safety of the individual, and personal health data must be firewalled from occupationally related data.

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APPENDIX C: STATEMENT ON FATIGUE AND ITS MANAGEMENT IN THE WORKPLACE

This Appendix addresses the underlying causes of mental fatigue in the workplace and provides some generally applicable strategies that can reduce accidents and injuries attributable to excessive fatigue. Excessive mental fatigue can have devastating effects on workplace safety and worker health and has contributed to many disasters such as Three Mile Island and the Exxon Valdez oil spill.[1] Mental fatigue and workplace sleepiness are primarily a function of time awake, time of day, and work/rest patterns. Occupational, social, and environmental factors often prevent individuals from obtaining the recommended 7 to 9 hours of daily sleep which leads to sleep loss that is often compounded by non-standard or rotating shifts that disrupt the body clock or misalign it with occupational and social demands.[2] Many occupations such as nursing, medicine, transportation, and public safety often require work shifts that extend well beyond 8 hours.[2,3] Also, in the US, millions of individuals take a second job sometimes in what is now called the "gig economy."

When sleep duration drops below 7 h/day, there is a graded degradation in cognitive function. After 5 days of sleep restricted to 5 h/day, measures of vigilance declined an average 12% (compared to those sleeping 7 h/day); and when sleep was restricted to 3 h/day, the degradation in performance averaged 26%.[4] In addition, many workers suffer from sleep disorders that impair workplace functioning.[2]

Workplace mental fatigue can also result from long duration shifts with intense mental demands without sufficient interspersed rest periods, as well as long boring tasks such as monitoring automatic processes or operating vehicles. Work periods >8 h increase risk of accidents and at 12 hours, the risk doubles.[2,5] Physical (musculoskeletal) fatigue and the injuries that can result also occur in the workplace but will not be addressed here.[6]

In the US, unlike the European Union, national standards for work hours do not exist although industries such as aviation and trucking are federally regulated.[2]

Fatigue Impact

Regardless of the sources of fatigue, failure to implement mitigation strategies can degrade performance and health.

Performance effects. Reduced sleep exerts cumulative adverse effects on cognitive performance that include reduced vigilance, increased lapses of attention, degradation in short term memory, logical reasoning and impulse control, and episodes of involuntary sleep.[2] Remaining awake for 20 to 24 hours produces performance decrements equivalent to blood alcohol levels of 0.08% to 0.10%.[2] Shift work which disrupts circadian cycles often compounds the impact of insufficient sleep. In certain circumstances, the combination of long work hours and shift work can increase accident rates by 50% to 100%.[5] It is not possible to fully adapt to non-standard sleep/wake schedules, and recovery from chronic sleep loss is slow and often incomplete.[4]

Health effects. Chronic insufficient, disrupted, and/or disordered sleep has been associated with chronic diseases such as diabetes and hypertension and with psychological conditions, including depression and anxiety. Substance

abuse, suicide, obesity, and overall mortality also have been associated with insufficient and/or disordered sleep.[2,7] Furthermore, sleep disturbances increase the risk of infectious and inflammatory diseases including colds, influenza, and herpes zoster (shingles), and some epidemiological research suggests shift work (which often results in sleep restriction as well as circadian disruption) may increase the risk of certain types of cancers.[2]

Fatigue Countermeasures

Adequate sleep is essential for proper fatigue management even though obtaining it and avoiding circadian disruptions are difficult in modern society. However, fatigue can be mitigated in part with proven countermeasures.[8] Any countermeasures implemented should be customized to the specific workplace and type of work in question. Various factors not discussed in this document such as environmental stressors (e.g., heat, cold), physical demands, and other factors should be taken into account.

Education. Personnel must be educated about the dangers of fatigue, the importance of adequate sleep, and facts about the slow recovery from sleep loss. Workers cannot manage problems if they are not fully aware of them.

Good sleep habits. Various strategies can optimize the restorative potential of available off-duty sleep opportunities. Employees should receive training on good sleep habits and other behavioral interventions.

Naps. Naps are valuable when full consolidated sleep periods are not feasible. Proper timing, sufficient length, and optimal placement within the circadian pattern are beneficial for workplace performance and using the correct practices can avoid post-nap sleepiness (sleep inertia).

Rest breaks. Short on-the-job rest breaks also positively impact alertness for short periods of time. They are most beneficial when employees can stand and engage in physical activity and/or social interactions. However, depending on the circumstances, napping, as discussed below, can also be an effective strategy.

Proper lighting. Light management can positively influence alertness and circadian alignment, but intensity, wavelength, exposure time, and correct placement with regard to circadian phase are essential. Properly timed bright light, particularly when blue-enriched, can increase arousal and facilitate better adaptation to a new schedule or to time zone changes. Blocking unwanted light exposure with special glasses can improve adaptation to night work and avoid increased alertness immediately prior to sleep.[9] Lighting customized for individual tasks and for workers with impaired vision can also be helpful.[10]

Caffeine. Caffeine is a non-prescription stimulant that is safe in moderate doses.[11] It enhances alertness in rested and sleep-deprived individuals. Caffeine in moderate doses can be obtained in single servings of coffee, tea, soft drinks, energy drinks, or caffeinated gum. Eighty percent of the US population regularly consumes caffeine, often for its alertness-enhancing properties.[12]

Sleep/alerting drugs. When scheduling, environmental, or work factors prevent proper rest, medications may be an option. Hypnotics can promote off-duty sleep, if opportunities for sleep are available, and stimulants can increase wakefulness if sleep-deprivation is unavoidable. The choice of hypnotics should take into account the speed and duration of its effects. Both prescription and over-the-counter options are available. Correct hypnotic use can improve sleep without creating post-sleep hangover effects. Prescription hypnotics or stimulants are not typically provided to workers except for the treatment of a diagnosed

sleep disorder such as primary insomnia, sleep apnea, narcolepsy or idiopathic hypersomnia. However, the stimulants modafinil and armodafinil are indicated for treatment of excessive sleepiness associated with shift work sleepiness disorder, narcolepsy, and obstructive sleep apnea; and both medications can enhance the alertness of shift workers.

Behavioral sleep-optimization techniques. When sleeping difficulties arise, sleep-optimization strategies such as stimulus control, relaxation, and cognitive therapies should be considered. These approaches, as well as meditation/ mindfulness training, may be effective; however, positive results may take time to achieve.

Identification/treatment of sleep disorders. This important countermeasure is often overlooked, but any condition that negatively affects the restorative value of sleep can adversely impact workplace performance. Diagnosis and treatment of sleep disorders such as insomnia, sleep apnea, restless legs syndrome, and periodic limb movement disorder will optimize on-the-job alertness and worker safety.

Fatigue monitoring technologies. Real-time monitoring of operator fatigue is usually not feasible but monitoring off-duty sleep can be beneficial. Continuous sleep/wake measurement via wrist actigraphy contribute to fatigue management since it assesses whether workers are obtaining 7 to 8 hours of daily sleep. However, worker privacy issues need to be carefully considered before implementing any type of monitoring program.

Bio-mathematical models. Combining actigraph-based sleep monitoring with mathematical fatigue-prediction models can track and reduce employee fatigue. Such models use validated algorithms that estimate individual fatigue as a function of sleep/wake patterns. Use of the Sleep, Activity, Fatigue, and Task-Effectiveness (SAFTE) model or other validated models (e.g., the Unified Model) can identify overly-fatiguing work schedules.[2]

Science-based shift-schedule planning. Designing work/rest schedules based on proven scientific principles is essential for avoiding fatigue-related adverse effects on performance, health, and morale in the workplace. Advice on factors such as the optimal number of consecutive night shifts, shift rotation periods, time between shifts, and shift lengths is available from a variety of sources.[2]

Fatigue Risk Management Systems (FRMS). An FRMS can reduce fatigue-associated risks by formally implementing procedures to ensure employees are getting sufficient sleep and are monitored for fatigue-related problems and organizations have controls to minimize fatigue-related errors.[2,13] It is essential that any plan be customized for the specific workplace and occupational tasks in question. It also is necessary to consider cultural factors when formulating guidance for specific workplaces. The schedules of some societies and occupations may differ from those of most industrial societies. For example, practices that are common in US manufacturing facilities may not be feasible for agrarian settings or among populations in which long afternoon rest periods that offer sleep opportunities are common.

Conclusions and Recommendations

Given the present state of knowledge, ACGIH considers that fatigue from excessive sleepiness in the workplace is a serious health, performance, and safety hazard. However, evidence-based strategies can promote better sleep, optimize

sleep/wake and work scheduling, and mitigate the impact of fatigue in real-world settings. Organizations are advised:

1. All personnel should be educated about the nature of workplace fatigue and that: a) fatigue is a serious problem; b) it is due to physiological changes in the brain and more than a state of mind; and c) it can be mitigated with proven strategies.
2. Mitigation strategies should include: a) workplace-based modifications (i.e., optimal lighting, workplace napping facilities, appropriate rest-break planning, and science-based scheduling practices); b) personnel-based practices (i.e., behavioral strategies for better sleep, proper use of alertness/sleep aids, and effective light-exposure management); and c) screening for disorders such as sleep apnea that degrade sleep.
3. Interventions should be implemented using a formal, carefully planned FRMS that is evidence-based, data driven, cooperatively designed, and integrated into the organization. It should be continuously improved, fully justified, and accepted by the workforce and management, including senior leaders as a safety and health priority.

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2024
Biological Agents

Contents

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BIOLOGICAL AGENTS

The term "biological agent" refers to a substance of biological origin (e.g., bacteria, fungi, plants and algae, viruses, and animals including arthropods and protozoans) capable of eliciting an adverse health effect (e.g., an infection or a hypersensitivity, irritant, inflammatory, or other adverse response). Bioaerosols are airborne particles derived from biological agents potentially consisting of whole cells that may or may not be viable, comminuted cellular components, metabolites, and metabolic byproducts. Biological agents are ubiquitous in nature but may be amplified by human activities. Biological agents may additionally emit microbial volatile organic compounds (mVOCs) during and following growth, both as direct and indirect products of their metabolism. Humans are perpetually exposed to a wide array of biological agents in varying combinations and concentrations. Normally occurring, low-level exposures to biological agents do not necessarily elicit a response, pose a health risk, or otherwise result in harm.

Indoor biological contamination can be defined as the presence of: 1) bioaerosols likely to cause or predispose humans to adverse health effects; 2) inappropriate indoor airborne concentrations of bioaerosols, as determined by consideration of space type or occupancy purposes; or 3) indoor microbial growth, amplification, or remnants of biological growth, or sources of infectious agents or pathogens, either deposited, accumulated, or amplified, that may become aerosolized and to which humans may be exposed.

TLVs exist for certain defined substances of biological origin, including cellulose, subtilisins (proteolytic enzymes), and some gases and mVOCs (e.g., carbon dioxide, acetone, ethanol, methanol, acetaldehyde) produced by living organisms. However, many biological agents are poorly defined and often multifarious in composition. For the reasons identified below, aside from the few TLVs relating to defined substances of biological origin, there are no TLVs against which to compare environmental air concentrations of the vast majority of biological agents, notably those involved in indoor biological contamination.

ACGIH has developed and separately published guidance on the assessment, control, remediation, and prevention of bioaerosols.[1] The ACGIH Bioaerosols Committee concurs that, at this time, the measurement and analysis of airborne concentrations of bioaerosols, other than those for which a TLV have been established, cannot be relied upon to determine whether conditions and exposures pose an adverse health risk. The ACGIH-recommended approach to assessing bioaerosol exposures relies on the visual inspection of buildings; assessment of adverse health symptoms; evaluation of building performance, including mechanical systems; identification of potential environmental sources of amplification, accumulation, and dissemination of biological agents; and application of professional judgment to establish an informed opinion on the potential for exposure to bioaerosols. ACGIH-published guidance provides background information on the major groups of biological agents responsible for bioaerosols, including their sources and health effects, and describes methods to collect, analyze, and interpret environmental samples.

Occasionally, environmental sampling (e.g., bioaerosol testing) detects a single, or predominant biological agent. More commonly, the results of environmental

or bulk sampling are inscrutable, revealing a mixture of many different biological agents contributed by myriad autochthonous and allochthonous sources. Therefore, environmental sampling should be conducted only by following careful formulation of testable hypotheses about potential reservoirs of biological agents and mechanisms by which humans may be exposed to bioaerosols arising from these sources. Even when investigators work from testable hypotheses using well-formulated sampling plans, results of environmental monitoring may be inconclusive or misleading. Interpretation of sample results is highly subjective and often not rooted in scientific or evidence-based information. In the case of bioaerosol sampling, poor repeatability of measurements, lack of widely accepted, standardly applied analytical methods, differences in individual susceptibility, and inherent variability in background concentrations, among other things, have complicated the determination of dose-response relationships and thus impeded the establishment of TLVs for: 1) culturable or countable bioaerosols (e.g., total bacteria, fungi, viruses, pollen); 2) specific culturable or countable bioaerosols other than infectious agents (e.g., *Alternaria alternata*); 3) infectious agents (e.g., *Legionella pneumophila*, SARS-COV-2, *Mycobacterium tuberculosis*); and 4) assayable biologically derived substances (e.g., mycotoxins, allergens, mVOCs).

1. Culturable or countable bioaerosols. Culturable bioaerosols are those biological agents (typically bacteria, viruses, and fungi) that, once sampled, can be detected and characterized by cultivation on laboratory growth media. The results of such analyses are reported as the number of colony-forming units (CFU), or in the case of viruses the number of plaque-forming units (PFU), per volume sampled (e.g., cubic meter of air). A CFU or PFU may consist of a single individual or a cluster of alike or diverse culturable biological agents. Countable bioaerosols consist of individual or aggregated particles mostly larger than 0.8 um in diameter (e.g., fungal spores, bacterial cells, pollen grains, etc.) that can be categorized and counted directly using light microscopy. A general TLV for culturable or countable bioaerosol concentrations is not scientifically supportable for the following reasons:

A. Culturable biological agents and countable bioaerosols do not comprise a single entity. Bioaerosols in environmental and nonagricultural settings differ in their qualitative and quantitative composition, typically consisting of complex mixtures of many different microbial, animal, and plant-derived particles.

B. Human responses to bioaerosols range from innocuous effects to serious or even fatal diseases depending on the specific agent(s) involved and the individual's susceptibility. Therefore, an appropriate exposure limit for one bioaerosol may be entirely inappropriate for another, and neither may be generalizable to a broad population.

C. Many methods are available to collect and analyze bioaerosol samples. However, different methods of sample collection and analysis often result in divergent estimates of culturable and countable bioaerosol concentrations, even when the same basic sampling methods are used. Many methods of bioaerosol characterization involve a degree of subjectivity and inter-analyst variability that further complicates their use in exposure assessment.

D. The inherent temporal, spatial, and compositional variability of bioaerosols in outdoor and indoor environments causes the estimation a time-weighted average (TWA) exposure using data from few or several "grab samples" to be unreliable. The number of samples required to overcome this limitation is often infeasible for assessments outside of research settings.

E. At present, information relating culturable or countable bioaerosol concentrations to health effects is generally insufficient to describe exposure–response relationships, although this is an active area of ongoing research.

2. Specific culturable or countable bioaerosols other than infectious agents. Specific TLVs for specified culturable or countable bioaerosols have not been established to prevent hypersensitivity, irritant, infectious, toxic, or other adverse health responses. At present, information relating culturable or countable bioaerosol concentrations to adverse health effects consists largely of case reports and qualitative exposure estimations, sometimes supported by area-based sampling. These types of data are insufficient to describe exposure-response relationships. Reasons for the absence of good epidemiologic data on such relationships include the following:

A. Most data on concentrations of specific bioaerosols are derived from proxy measurements rather than from measurements of actual effector agents. For example, some investigators use the airborne concentration of culturable fungi to infer exposure to airborne fungal antigens. In addition, most measurements are derived from either area air samples or source samples. These monitoring approaches are, at best, crude predictors of human exposure. Personal sampling for actual effector agents would be needed to support the establishment of a TLV.

B. Bioaerosol composition and concentrations vary widely within and among different occupational, residential and environmental settings. Replicate sampling is uncommonly practiced in building assessments. Furthermore, the most commonly used air sampling devices for indoor monitoring are designed to collect “grab” samples over relatively short time intervals. Measurements from single, short-term grab samples may be one or more orders of magnitude higher or lower than long-term average concentrations and are unlikely to represent occupant exposures accurately. Some organisms and sources release aerosols as “concentration bursts” or through activity-mediated resuspension of settled dusts creating a “personal cloud” which may only rarely be detected by grab sampling. Nevertheless, such episodic and transient bioaerosol releases may produce significant health effects.

C. In studies of single workplaces and residential buildings, the number of persons affected by exposure to biological agents is often small and contamination is localized, thereby affecting only a fraction of the building occupants. Meta-analysis of such studies is challenging because the specific types of biological agents responsible for bioaerosol-related illnesses are diverse and often differ from study to study, and the actual effector agents are rarely, if ever, characterized. These factors contribute to the low statistical power common in evaluations of cause–effect relationships between exposures to specific biological agents and building-related adverse health complaints.

3. Infectious agents. There are few air sampling protocols for monitoring communicable and noncommunicable infectious agents, and the equipment to conduct this type of sampling is often costly, inaccessible, and unreliable. As such, there is a paucity of good quality human exposure-response data for most infectious bioaerosols, precluding the establishment of TLVs for these agents. Mitigation

of risk to infectious bioaerosols is normally achieved through the elimination or control of reservoirs using administrative and engineering controls, and the use of personal protective equipment (PPE). Air monitoring for these agents may be useful in academic research or as part of an overall informed assessment of infectious bioaerosols in high-risk environments, such as health care or manufacturing. In most routine exposure settings, public health measures such as medical monitoring, prophylaxis, immunization, case tracking, source control, and medical treatment remain the primary defenses against infectious bioaerosols. Facilities with an increased risk of transmitting airborne infectious diseases (e.g., microbiology laboratories, animal-handling facilities, and health care environments) should employ engineering controls (such as ventilation and filtration) to minimize airborne concentrations of infectious agents and thereby reduce exposures. Such facilities should also implement administrative controls, and provide respiratory or other PPE, where indicated, to reduce worker exposures to infectious bioaerosols.

4. Assayable biologically derived contaminants. Biologically derived contaminants, such as endotoxins, mycotoxins, antigens, allergens, and mVOCs, are detected using chemical, immunological, or biological assays. Evidence does not yet support TLVs or BEIs for any of these substances. However, assay methods for certain common airborne antigens and endotoxin are steadily improving, and field validation of these assays is also progressing. Dose-response relationships for some assayable biologically derived contaminants have been observed in experimental studies and occasionally in epidemiologic surveys. Therefore, the development of exposure limits for certain assayable, biologically derived airborne contaminants may be possible in the future.

ACGIH actively solicits information, comments, and data in the form of peer-reviewed literature on health effects associated with bioaerosol exposures in occupational and related environments that may help the ACGIH evaluate the potential for proposing exposure guidelines for selected biological agents. Such information should be sent in electronic format to the ACGIH Science Group at science@acgih.org.

Reference

1. Macher JM, Ammann HM, Burge HA, Milton DK, Morey PR, eds. Bioaerosols: assessment and control. Cincinnati (OH): ACGIH; 1999.

BIOLOGICAL AGENTS UNDER STUDY

The TLV Bioaerosols Committee notes that there are no biological agents under study by ACGIH. However, ACGIH solicits information, especially data, which may assist it in the establishment of TLVs for biological agents. Comments and suggestions, accompanied by substantiating evidence preferably in the form of peer-reviewed literature, should be forwarded in electronic format to the ACGIH Science Group at science@acgih.org. Please refer to the ACGIH TLV/BEI Development Process found on the ACGIH website for a detailed discussion covering this procedure and methods for input to ACGIH (acgih.org/science/tlv-bei-guidelines/policies-procedures-presentations/tlv-bei-development).

The Under Study list is published on the ACGIH website (https://www.acgih.org/science/tlv-bei-guidelines/documentation-publications-and-data/under-study/) and later in the annual TLVs and BEIs book.

The substances and issues listed below are current as of December 1, 2023. After this date, please refer to the ACGIH website (https://www.acgih.org/science/tlv-bei-guidelines/documentation-publications-and-data/under-study/) for the up-to-date list.

Agents

None

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Endnotes and Abbreviations

*	2024 Adoption.
‡	See Notice of Intended Changes (NIC).
( )	Adopted values or notations enclosed are those for which changes are proposed in the NIC.
†	2024 Revision or Addition to the Notice of Intended Changes.
A	Refers to Appendix A: Carcinogenicity.
C	Ceiling limit; *see* definition in the "Introduction to the Chemical Substances."
(D)	Simple asphyxiant; *see* discussion covering *Minimal Oxygen Content* found in the "Definitions and Notations" section following the NIC tables.
(E)	The value is for particulate matter containing no asbestos and <1% crystalline silica.
(EX)	Explosion hazard: the substance is a flammable asphyxiant or excursions above the TLV that could approach 10% of the lower explosive limit.
(F)	Respirable fibers: length >5 µm; aspect ratio ≥3:1, as determined by the membrane filter method at 400-450× magnification (4-mm objective), using phase-contrast illumination.
(G)	As measured by the vertical elutriator, cotton-dust sampler; *see* the TLV Documentation.
(H)	Aerosol only.
(I)	Inhalable particulate matter; *see* Appendix C, paragraph A.
(IFV)	Inhalable fraction and vapor; *see* "Notations/Endnotes" section, p. 74.
(J)	Does not include stearates of toxic metals.
(L)	Exposure by all routes should be carefully controlled to levels as low as possible.
(M)	Classification refers to sulfuric acid contained in strong inorganic acid mists.
(O)	Sampled by method that does not collect vapor.
(P)	Application restricted to conditions in which there are negligible aerosol exposures.
(R)	Respirable particulate matter; *see* Appendix C, paragraph C.
(T)	Thoracic particulate matter; *see* Appendix C, paragraph B.
(V)	Vapor fraction.
B	Background; *see* BEI Intro.
BEI	Substances for which there is a Biological Exposure Index or Indices (*see* BEI section). BEI_C: *see* BEI for Cholinesterase inhibiting pesticides BEI_M: *see* BEI for Methemoglobin inducers BEI_P: *see* BEI for Polycyclic aromatic hydrocarbons (PAHs)
DSEN	Dermal sensitization; *see* definition in the "Definitions and Notations" section.
MW	Molecular weight.
NOS	Not otherwise specified.
Nq	Nonquantitative; *see* BEI Intro.
Ns	Nonspecific; *see* BEI Intro.
OTO	Ototoxicant; *see* definition in the "Definitions and Notations" section.
Pop	Population based
RSEN	Respiratory sensitization; *see* definition in the "Definitions and Notations" section.
SEN	Sensitization; *see* definition in the "Definitions and Notations" section.
Skin	Danger of cutaneous absorption; *see* discussion under *Skin* in the "Definitions and Notations" section.
SL	Surface Limit; *see* definition in the "Introduction to the Chemical Substances."
Sq	Semi-quantitative; *see* BEI Intro.
STEL	Short-term exposure limit; *see* definition in the "Introduction to the Chemical Substances."
TWA	8-hour, time-weighted average; *see* definition in the "Introduction to the Chemical Substances."
ppm	Parts of vapor or gas per million parts of contaminated air by volume at 25°C and 760 torr.
mg/m^3	Milligrams of substance per cubic meter of air.
µm	micrometers.

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