records available to the Assistant Secretary, the Director, the employee, and his or her designated representative. Such access is necessary for the agency to monitor compliance with the rule and to carry out its statutory responsibilities. Access is also important for employees so that they have information relevant to their exposure to toxic substances and are aware of health consequences.

OHSA's final rule also requires that employers who go out of business without a successor employer to receive and retain their records for the prescribed period of 30 years notify the Director at least 90 days prior to disposal and then transfer the records to the Director (paragraph (n)(6)(ii)). This provision is in accord with 29 CFR 1910.20, and is an important method of ensuring the continuity and accuracy of long-term record maintenance.

There was broad general support in the record for a recordkeeping requirement in the asbestos standard for construction (Exs. 84–307, 330, 123–A, 312.A, Trs. 6/20, 6/28, 7/3, 6/26). For example, Robert Cooney, reading the statement of Robert Georgine for the Building and Construction Trades Department, AFL–CIO, stated:

> Unless appropriate methods of compliance, measurement, monitoring, reporting and documentation, and employee medical provisions are contained in the standard, the statutory mandate will not be fulfilled, and construction workers will not be adequately protected. (Tr. 6/27, p. VII–72)

However, comments varied regarding the detail of the records the length of time they should be maintained, and their accessibility. Two commenters argued against the feasibility of generating and maintaining detailed records for 30 years in the construction industry.

In a post-hearing submission (Ex. 308), David Potts, Director of Safety and Health for the National Constructors Association (NCA), argued that recordkeeping was impractical in the construction industry. In support of this position, Mr. Potts re-submitted the testimony NCA had submitted previously in response to OSHA's proposal to modify the Records Access rule. In this testimony (Ex. 308, Attachment E), NCA cited the Lead decision (*United Steelworkers of America, AFL–CIO–CLC* vs. *Donovan*) as precedent for excluding the construction industry from the monitoring activities that would lead to the generation of exposure records. In this earlier submission, NCA claimed that OSHA's requirements for records access were not reasonable for the construction industry because the industry was "unique" and "cannot be treated like general industry for the purposes of OSHA regulation" (Ex. 308, Attachment E, p. 4).

Elihu Leifer and Mary Vogel, attorneys for the BCTD, disagreed with NCA and stated that NCA had "misread" the Lead decision. The BCTD's post hearing brief stated that

> . . . OSHA essentially . . . found [in the *Lead* decision] that to apply the Lead standard to the construction industry would be infeasible because it would be impractical to conduct *environmental* monitoring. (Ex. 330, p. 132)

BCTD further maintained that OSHA's support of the exemption of the construction industry from the lead standard extended only to "lead exposures in the construction industry and not, as NCA would lead one to believe, as regards to all toxic substances." and that "OSHA's decision to exempt the construction industry from the lead standard cannot appropriately be compared with an exemption [of this industry] from the requirements in the asbestos standard" (Ex. 330, p. 132–133). OSHA agrees with the BCTD that the Lead decision provides no basis for exempting the construction industry from recordkeeping requirements for asbestos. Unlike the case for lead, conducting air monitoring and medical surveillance for construction workers exposed to asbestos is feasible and is routinely done by most construction employers today.

R.F. Boggs, Ph.D., Vice President of Organization Resources Counselors, also opposed the requirement that the construction industry be required to create and maintain detailed exposure and medical records for 30 years. He included a statement by Carl D. Richardson of Brown and Root, Inc., who said that "[the records] have no effective purpose in an industry where employment is temporary and the work location is highly variable" (Ex. 123–A, Appendix B, p. 7).

However, in support of the feasibility of recordkeeping in the construction industry, Dr. Morton Corn of the Johns Hopkins School of Hygiene and Public Health, pointed out that the IBM Corporation had as early as 1979 set up a detailed recordkeeping system for the exposure records of monitoring performed during the renovation of buildings and the removal of friable, sprayed-on asbestos (Tr. 7/3). IBM kept records of all airborne asbestos concentrations outside the barrier area as well as within and they kept records of the procedures used (Tr. 7/3, p. 17). Joe Adam of the BCTD argued that monitoring (and recordkeeping) is not only feasible but necessary because it can be used to form an acceptable data base and to assure that decisions reached on controlling asbestos in the work environment are effective (Tr. 6/28, p. 252). David Kirby, Industrial Hygiene Chemist for the Alabama Safe State Program, also supported inclusion of a requirement for the creation and maintenance of detailed records. He noted that with computers, microfiche, and other modern data storage systems, detailed recordkeeping requirements were both feasible and valid (Tr. 6/20, pp. 186–187).

The BCTD and Mr. Kirby point out that the 30-year retention period is important because of the long latency periods associated with asbestos disease (Ex. 330, pp. 128–129; Tr. 6/20, pp. 186–187). Mr. Leifer and Ms. Vogel, attorneys for the BCTD, pointed out that employees are entitled to medical examinations to determine the effects of asbestos exposure on their health. Medical examinations are also important for the prevention, early detection, and treatment of asbestos-related disease (Ex. 330, pp. 137–138). Records of these examinations must be kept for 30 years not only for medical and research reasons but also for monitoring the effectiveness of and compliance with the standard (Ex. 330, pp. 128–129).

Since OSHA does not mandate specific methods of recordkeeping, employers are free to use the services of competent organizations such as industry trade associations and employee associations to maintain the required records. To reduce the costs and facilitate recordkeeping, the BCTD described approaches used by several groups (Ex. 330). For example, the Painters Union has had a centralized medical recordkeeping system covering 3,000 workers since October 1980. It is financed through employer contributions (Tr. 6/28, pp. 32–33). Sweden has also implemented a nationwide centralized medical recordkeeping system. In addition, some contractors have already engaged in joint recordkeeping efforts for other purposes. For eample, the Texas affiliate of the ABC, a contractor's association, operates a joint recordkeeping system in the nature of a job bank for the benefit of its members (Tr. 6/28, p. 126). OSHA believes that centralizing recordkeeping will alleviate the problem of lost records associated with the transient nature of the construction workforce and the frequency of business closures in this sector (Ex. 84–233, pp. 32–33).

In conclusion, OSHA finds that the record evidence fully supports the