Pulmonary Function Testing Newsletter June 2026

Featured Courses: **Spirometry Refresher (NIOSH-approved):**
August 25, 2026
Interpretation of Spirometry - Beyond the Numbers:
August 26, 2026

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2026 Spirometry Course Schedule

Spirometry - NIOSH-approved initial course:
June 16-18, 2026
Sept 15-17, 2026
Nov 10-12, 2026

Spirometry Refresher (NIOSH-approved):
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To submit a registration request, go to www.DrMcKay.com
or , email info@drmckay.com and ask for a training course registration request form

Spirometry Interpretation Comments

From the perspective of someone who routinely reviews spirometry reports from many different organizations, it's clear the majority of reports are inadequate. Most common reasons are:

1) tracings are too small, and
2) belief that the 3 best tracings are sufficient to properly interpret a spirometry test.

Minimum spirometry guidelines (ATS, ERS, and others) permit the display and printing of the 3 best tracings. This gives the false impression that doing so is adequate for interpretation. While this may be sufficient for hospital-based pulmonary function laboratories using highly trained, experienced, and well-supervised operators, it is **not** adequate for the majority of spirometry testing programs. Most spirometry tests are conducted by personnel with limited training, using equipment configured to meet minimum spirometry standards.

Persons who interpret spirometry tests are dependent on how the testing was performed and how the equipment is configured. They interpret only what is presented to them. Because they don't see a complete picture, they rely more heavily on numerical data and computer interpretation, particularly when all of the information is not displayed. In these cases, the interpreter cannot fully assess lung function, patient cooperation, or effort. This is an unfortunate consequence of "minimal" guidelines that do not emphasize optimal practices. Printing or displaying only the 3 best tracings is clearly inadequate. Perhaps future spirometry guidelines will recognize this problem and address it. This issue becomes more problematic when many trials are performed and tracings are not staggered. **To put it bluntly, looking at the 3 best tracings doesn't tell the whole story. In this case, neither does the interpretation.**

The goal of spirometry is **not** convenience; it is accurate clinical interpretation. A concise report may be easier

to review, but it risks oversimplification and misinterpretation. This is particularly problematic in occupational health and primary care settings.

Simplicity should never come at the expense of completeness when clinical accuracy is at stake. It must not only be performed correctly, it must be documented in a way that demonstrates quality and validity.

Next time you interpret a spirometry test, ask yourself the following question. What's more important?

Looking at a 1-page report because its simple and convenient or looking at a report that provides a comprehensive picture of the entire testing session?

FEV1Q Across Borders: A Promising Metric or Another Layer of Complexity?

A recent study by Alayadhi and colleagues evaluated the performance FEV1Q (forced expiratory volume in one second quotient) in a large, under represented population from Nepal, Peru, and Uganda. Using data from more than 10,000 community-dwelling adults aged 40 and older, the investigators examined whether FEV1Q, a metric calculated by dividing FEV1 by a fixed "lowest survivable" value, holds up across a diverse population in the "Global South" (see next article for clarification). They reported overall first percentile FEV1 values in individuals with COPD as 0.43 L in women and 0.52 L in men,), which are consistent with those originally described in United Kingdom cohorts (0.40 L in women and 0.50 L in men).

Beyond derivation, the study demonstrated that lower FEV1Q values were associated with worse respiratory health, including greater symptom burden, prior hospitalizations, and increased risk of future hospitalization. FEV1Q also declined with age and smoking exposure, reinforcing its relationship to known determinants of lung function. Importantly, the authors showed that pre-bronchodilator FEV1Q performed similarly to FEV1 percent predicted in identifying COPD, suggesting a potential role in screening or case-finding, particularly in settings where full spirometry with bronchodilator testing may be impractical.

Taken together, these findings support the concept that FEV1Q may offer a simple and clinically meaningful way to express lung function across diverse populations. However, as highlighted in an accompanying editorial (Russell & Kempker), while the study adds to the evidence base and suggests relative stability of the FEV1Q construct, it does not settle the ongoing debate regarding whether FEV1Q is superior, or even equivalent, to established indices such as FEV1 percent predicted or Z-scores.

The editorial emphasizes that transforming FEV1 into a quotient primarily changes its scale and interpretation, rather than fundamentally altering its relationship to clinical outcomes. Although FEV1Q showed similar diagnostic performance to traditional metrics, differences were small and may not justify a shift in practice. The lack of established thresholds for defining normal versus abnormal FEV1Q further limits its immediate clinical applicability, and the authors caution that attempting to use FEV1Q diagnostically may introduce complexities similar to those already encountered with existing approaches.

From a practical standpoint, several observations from this work deserve closer attention. First, there were clear geographic differences in both absolute FEV1 values and first percentile estimates, particularly among females. For example, the first percentile FEV1 in women ranged from 0.39 L in Peru to 0.55 L in Uganda, a difference of 160 mL. These values also differ from those originally derived in United Kingdom populations, reinforcing that "survivable" thresholds may not be as universal as initially proposed. Similarly, both absolute lung function and FEV1Q values varied by country, reflecting the influence of environmental, developmental, socioeconomic, and exposure-related factors on lung health. These findings support longstanding observations that lung function differs by geographic region and call into question the current trend toward global or blended reference equations without deeper consideration of regional variability.

Finally, when considering FEV1Q as a tool for monitoring longitudinal change, the study again highlights variability across populations. The estimated decline in FEV1Q per decade differed meaningfully by country, approximately 0.54 units in Uganda versus 0.79 units in Nepal, suggesting that even age-related changes are not uniform across settings. In this context, FEV1Q does not appear to offer a clear advantage over traditional approaches that track absolute volume change in FEV1, which have been extensively validated in both cross-sectional and longitudinal studies. At present, while FEV1Q is an intriguing and potentially useful adjunct, particularly in resource-limited settings, it should be viewed as complementary rather than a replacement for established spirometric indices, pending further evidence.

For additional information, go to the source:

Alayadhi A, et.al. FEV1Q as a race-neutral assessment of lung function in Nepal, Peru and Uganda. *Eur Respir J* 2026; 67: 2501830 [DOI: 10.1183/13993003.01830-2025].

Russell ST & Kempker JA. FEV1Q: the quest for an optimised measure of lung function impairment goes to the Global South. *Eur Respir J* 2026; 67: 2502697 [DOI: 10.1183/13993003.02697-2025].

Clarifying "Global South"

You may be wondering why the authors in the Alayadhi et al., study refer to the "**Global South**,"when Nepal is in the northern hemisphere! The answer is they're not using a strictly geographic definition based on location. Instead, "Global South" is a socioeconomic and developmental construct that is used in public health, epidemiology, and global medicine. In this respect, "Global South" is used to describe countries that generally share characteristics such as:

- Lower or middle income status
- Under representation in biomedical research data sets
- Different environmental, occupational, and life-course exposures (e.g., using biomass fuel, infections, air pollution)
- Limited access to advanced diagnostic resources (spirometry with bronchodilators, other PFTs)

Historically, spirometric reference equations may have excluded or sparsely represented low and middle income populations, which may introduce error or bias.

Quantifying Life Expectancy and Years of Life Lost with COPD

In an editorial by Drs. Brender and Grady (JAMA Internal Medicine, published online May 17, 2026), they highlight new findings from Bhatt and colleagues examining life expectancy and years of life lost (YLL) associated with chronic obstructive pulmonary disease (COPD). Drawing on a large, diverse U.S. cohort, the underlying study reinforces the substantial impact of COPD on life expectancy, showing that individuals with the condition lose, on average, nearly two years of life compared with those without it. The loss increases significantly with disease severity, reaching more than seven years in advanced stages.

The authors emphasize that COPD's effect on lifespan is comparable to, or greater than, several other common chronic conditions. They also note this data provides meaningful context for clinicians and patients, especially when discussing prognosis and treatment decisions. The availability of life expectancy estimates across different ages, smoking histories, and disease stages may help guide more personalized care conversations. Importantly, the editorial underscores the strengths of the research, including its large sample size, long-term follow-up, and inclusion of both smokers and non-smokers. These features enhance the relevance of the findings and strengthen confidence in their applicability to contemporary clinical practice.

As the authors make clear, translating complex epidemiologic findings into concise summaries, such as this one, is inherently challenging, and it is difficult to fully capture the nuance of the original work without risking oversimplification or inadvertent overlap with the authors' language. Readers are encouraged to review the full editorial for a more complete understanding.

For additional information, go to the original sources.

Editorial:

Brender TD, Grady D. Quantifying Life Expectancy and Years of Life Lost in a Large Contemporary Cohort of Individuals With COPD. JAMA Internal Medicine. Published online May 17, 2026. doi:10.1001/jamainternmed.2026.0213

Article:

Bhatt SP, Sun Y, Wang Y, et al. Life expectancy in chronic obstructive pulmonary disease. JAMA Intern Med. published online May 17, 2026. doi:10. 1001/jamainternmed.2026.0207

Pulmonary Fun Facts

This section shares pulmonary function related facts, points of interest, and tidbits.

Cough

In a review article titled Unexplained or Refractory Chronic Cough by Irwin & Madison (*NEJM*, Mar 2025), they report that coughs can achieve high intrathoracic pressures up to 300 mmHg[7], velocity greater than 500 miles per hour[8], and chest energy up to 25 J[9], during vigorous coughing in healthy persons.

7 Sharpey-Schafer EP. The mechanism of syncope after coughing. Br Med J 1953; 2: 860-3.

8 Special acts involving breathing. In: Comroe JH. Physiology of respiration: an introductory text. 2nd ed. St. Louis: Mosby-Year Book, 1974: 230-1.

9 Wei JY, Greene HL, Weisfeldt ML. Cough-facilitated conversion of ventricular tachycardia. Am J Cardiol 1980; 45: 174-6.

Why Spirometry Interpretation Demands More Than a Computer Algorithm

Many spirometry devices used in workplace and primary care settings rely on outdated, opaque algorithms that often fail to meet current clinical guidelines. These computerized interpretations rarely disclose their source or date, overlook test quality, and reduce complex respiratory patterns to simplistic labels like "obstructive" or "restrictive." Worse, they seldom indicate the direction or magnitude of error when results are suboptimal. That's why it's critical for health professionals to go beyond merely accepting a computer-generated statement.

NIOSH-approved spirometry training programs focus on testing technique, calibration checks, and criteria for acceptability and repeatability-not interpretation. While they offer limited exposure to basic patterns, they do not equip attendees to recognize the wide range of abnormal results that may require physician follow-up. This gap underscores the need for specialized training in interpretation.

Cigarette Smoking in U.S. Drops to 9.9%

In a study published in *NEJM Evidence*, cigarette smoking among U.S. adults dropped from 10.8 to 9.9%. For adults aged 18-24, e-cigarette use surpassed traditional smoking. Overall, 18.8% of U.S. adults (47.7 million) used at least one tobacco product.
For those interested in current statistics, the report includes a comprehensive table identifying the percentage of adults using different types of tobacco products by gender, age group, race/ethnicity, rural/urban, education, etc.
For additional information, go to the source: Israel Agaku. Tobacco Product Use among U.S. Adults, 2023–2024. NEJM Evid 2026;5(4), 2026. DOI: 10.1056/EVIDpha2500339. Or Click Here

Understanding Bronchiectasis Progression:
What PFT Technicians Should Know

In a 2026 editorial by Oleksandr Mazulov, he summarizes recent developments in bronchiectasis and specifically results from a newly published study by Khalalli and colleagues (see sources below). He reports that Bronchiectasis is gaining renewed attention as both pediatric and adult cases become better recognized and diagnosed. Recent evidence highlights that for many adults, their disease actually began much earlier in life than previously appreciated. This distinction as to whether or not, bronchiectasis starts in childhood or adulthood, can have a major impact on what we observe during pulmonary function testing.

Pediatric versus adult-onset Bronchiectasis:
In the Khalalli study comparing over 1,400 adults with bronchiectasis, they found clear differences between Pediatric-Onset Bronchiectasis (POBE) and Adult-Onset Bronchiectasis (AOBE). Adults whose disease began in childhood showed more severe clinical, radiologic, and microbiologic features, even though they were, on average, 15 years younger than those with adult-onset disease.

To summarize what they found:

Lower Lung Function:
POBE patients showed significantly lower FEV_1 values (70.8% predicted) compared to AOBE patients (84.2% predicted).

More Extensive Airway Damage:
Radiographic scoring revealed greater structural disease in POBE vs AOBE.

Higher Rates of Chronic Infection:
POBE patients more frequently carried bacteria such as Pseudomonas aeruginosa and Haemophilus influenzae

More Frequent Exacerbations:
Median annual exacerbations were 2 in POBE vs 1 in AOBE, contributing to progressive lung injury.

Pediatric-Onset disease tends to be worse. POBE patients typically have much longer disease duration, compared to AOBE. This prolonged exposure to infection, inflammation, and airway damage leads to a more advanced disease state by adulthood.
Additionally, children who develop bronchiectasis often have identifiable underlying conditions such as:
Primary Ciliary Dyskinesia (PCD)
Primary Immunodeficiency (PID)
Protracted Bacterial Bronchitis

These conditions drive early and ongoing damage and

are more commonly found in POBE than in AOBE.

As a pulmonary function testing technician, you may see:

1. More Severe Obstruction in POBE
   Expect lower FEV_1 and FEV_1/FVC ratios, increased air trapping, and greater variability between visits.
2. Greater Chronicity of Symptoms
   Patients with POBE often report lifelong productive cough, frequent infections, or a long history of respiratory issues.

Given the progressive nature of bronchiectasis, especially in long-standing pediatric-onset cases, high-quality spirometry is essential for monitoring decline. Evidence suggests that when bronchiectasis is identified and treated early, particularly in childhood, there may be potential for partial reversibility. Clearly more evidence is needed. But, early detection and follow-up likely matters.

For testing technicians, recognize that Bronchiectasis often begins decades before adult diagnosis. Adult patients with pediatric-onset disease typically exhibit more severe lung impairment and high quality spirometry plays a vital role in documenting progression and supporting clinical decision-making.

For additional information go to:

Mazulov O. Early origins of chronic lung diseases: bronchiectasis takes the lead. *Eur Respir J* 2026; 67: 2501859 [DOI: 10.1183/13993003.01859-2025].

Khalaili L, et. al. Greater disease severity in adults with paediatric-onset versus adult-onset bronchiectasis: a multicentre EMBARC registry study. *Eur Respir J* 2026; 67: 2500665.

Smoking, Lung Cancer & Medicare Help

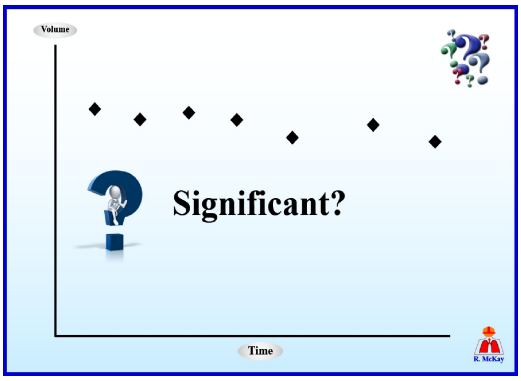
Most readers of this newsletter know that the most important thing you can do to prevent lung cancer is not smoke. But, did you know Medicare has programs to help those who want to quit smoking? If you need help, Medicare covers up to 8 counseling sessions in a 12-month period to help you stop smoking or using tobacco.

If you're at risk for developing lung cancer, Medicare also covers a lung cancer screening once a year. Talk with your doctor to find out if you're at risk and whether this screening is right for you.

For information go to: www.Medicare.gov
Then > What's covered > Counseling to prevent tobacco use & tobacco-caused disease

Evaluating Change in Spirometry?

Are you curious if spirometry tests on a worker or patient have a significant change in lung function? Need an expert opinion? Calculations using percent change and other methods are notorious for producing false positive and false negative results. Most methods lack reliable criteria to distinguish true change from normal aging and/or variability. Calculating FEV_1Q has serious limitations and lacks a recognized endpoint. If you have five (5) or more test dates, Dr. McKay can perform an expert independent analysis using multiple models, rather than relying on a single model. A straightforward answer, along with tabular and graphic displays, are included with a simple to read report and expert opinion. Depending upon available data, analysis can include calculations evaluating potential for peripheral airway collapse, not detectable using FEV_1 alone. For additional details, email Dr. McKay at roy@drmckay.com and request additional information.



2026 Spirometry Training Course Schedule

The University of Cincinnati is pleased to announce the remaining training course schedule that may be of interest to you or your staff. They are:

NIOSH-Approved Spirometry (initial course):
June 16-18, 2026
Sept 15-17, 2026
Nov 10-12, 2026

Spirometry Refresher (NIOSH-approved):
August 25, 2026
Also available online

Interpretation of Spirometry - Beyond the Numbers:
August 26, 2026

Online Spirometry REFRESHER Training (NIOSH-approved):
This online, self-paced course fulfills requirements for NIOSH-Approved Spirometry **Refresher** training necessary for compliance with some OSHA standards.
To receive a course brochure, email

Roy@DrMcKay.com or Click Here
For a brief 2 minute Video Description:
https://youtu.be/uu8UQ0j-S9E

Online Fundamentals of Spirometry:
This interactive online, self-paced course is designed to teach essential spirometry testing procedures consistent with current ATS-ERS spirometry guidelines.
To receive a course brochure, email Roy@DrMcKay.com or Click Here

Click here for information, fees, or to submit a registration request

Reminder: Refresher Training Due Dates
If your last initial or refresher spirometry training was in 2021, your re-certification **due date is 2026**.
Students who wish to maintain NIOSH Spirometry certification must take a NIOSH-approved Refresher program **every 5 years**. Currently, a 7-month extension is granted for eligibility.
Next in-person Refresher course date is:
August 25, 2026

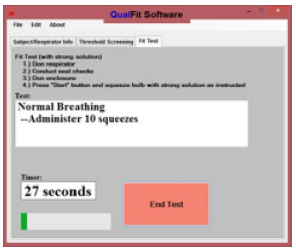
On-line, self-paced Refresher training, taken at your own convenience, is also available.

For details visit www.DrMcKay.com and look at the our Refresher course information section.

QualFit® Software©

An easier, more accurate, and defendable way to administer respirator fit tests using sweet or bitter fit test methods.

QualFit® software© automates and records qualitative respirator fit testing using Saccharin and/or Bitrex aerosol solutions. The software prompts the operator to deliver the aerosol solution with the correct number of squeezes for each exercise, at the proper time, and in the proper order. This improves fit testing accuracy. The software displays the current exercise in progress, automates the timing sequence and calculates the number of squeezes to be administered, based on threshold screening results. Visual and audible prompts allow the operator to focus their attention on the respirator wearer. The entire procedure becomes less frustrating for the operator and subject being tested. The software tracks each step of the fit testing procedure required in mandatory Appendix A of the OSHA Respirator Standard. **QualFit®** software improves the quality and efficiency of respirator fit testing. An OSHA compliant report can be printed or electronically saved. The employer benefits by knowing the test procedure was properly administered and provides written documentation for compliance with record keeping requirements specified in paragraph "m" of the OSHA standard. The employee benefits by knowing a standardized procedure was followed, rather than what often appears to be a random procedure.



QualFit® - Making Respirator Fit Testing Simple

For Information visit: www.QualFit.net
To place a secure online credit card order visit:
https://qualfit-software.square.site/

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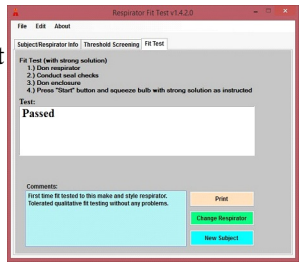
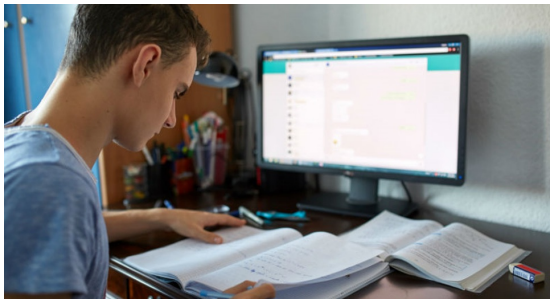
QualFit® Software© is registered with the U.S. Copyright Office June 13, 2021.

Final screen indicating test passed and operator comments. Includes option to print now or later, change to a different respirator, or select a new subject.



Online Spirometry Training Courses



Online Spirometry REFRESHER Training (NIOSH-approved):

This online, self-paced course fulfills requirements for NIOSH-Approved Spirometry **Refresher** training necessary for compliance with some OSHA standards. Course content was developed by Dr. McKay (University of Cincinnati) and includes the most recent changes to ATS-ERS spirometry standards. Upon successful completion of this course, students will receive a NIOSH-Approved Spirometry **Refresher** training certificate.

To receive a course brochure, email Roy@DrMcKay.com or Click Here

Click here for information, fees or to submit a registration request

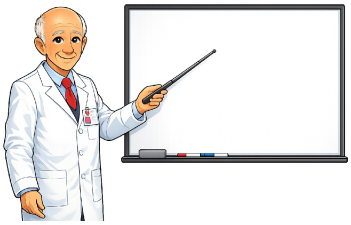
For a brief 2 minute Video Description:
https://youtu.be/uu8UQ0j-S9E

Online Fundamentals of Spirometry:

This interactive online, self-paced course is designed to teach essential spirometry testing procedures consistent with current ATS-ERS spirometry guidelines. It includes; terminology, how to administer a test, testing technique, acceptability/repeatability criteria, how to read tracings, and much more. This course is designed for persons who plan to conduct spirometry testing in an office, clinical and some occupational health settings. It can help prepare respiratory therapists taking the RPFT exam and occupational health nurses taking the COHN exam. It is **not** a replacement for persons who need a NIOSH-approved spirometry training certificate.
To receive a course brochure, email Roy@DrMcKay.com or Click Here

Click here for information, fees, or to submit a registration request

In-person Training opportunities



NIOSH-Approved Spirometry Training

This 3-day "initial" training course is designed for persons who need to learn how to administer spirometry testing according to the most recent 2019 ATS/ERS guidelines. This “hands-on” training covers all aspects of spirometry testing and uses a combination of lecture, hands-on training and small group problem solving sessions.

Next NIOSH-approved Spirometry course dates:
June 16-18, 2026
Sept 15-17, 2026
Nov 10-12, 2026

Certificates for persons that successfully complete all training requirements will indicate 22 contact hours with 2.2 CEUs from the University of Cincinnati.

Spirometry Refresher NIOSH-approved

Refresher training is **required every 5-years** for testing technicians who wish to maintain their current NIOSH-approved training status. Refresher training is also recommended by the American Thoracic Society (ATS), European Respiratory Society, and other organizations. This one-day course will be given by Roy McKay, Ph.D., a contributing author to the previous ATS/ERS Spirometry standard used worldwide. This Refresher course reviews the most recent spirometry testing guidelines, spirometry patterns (flow & volume), methods to improve testing technique, occupational surveillance concerns, and basic spirometry patterns. Examples of acceptable or usable, and unacceptable tracings will be shown to help the student recognize if the tracing has usable versus acceptable information. This course is also an excellent way to obtain answers to questions not foreseen during initial training and maintain your NIOSH-approved certification status.

Partial Listing of Course Topics

* Changes to spirometry standards.
* Definitions & Significance of:
  FVC, FEV_1, $FEF_{25-75\%}$.
* Review and improve proper test procedures and subject preparation.
* Recognition of unacceptable maneuver performance.

* How to identify an improperly performed test.
* How to use the Flow - Volume display to improve test performance.
* How to use Peak Flow to evaluate subject effort.
* How to recognize obstructive & restrictive patterns.
* Recognition of artifacts that impact patient test results (e.g., zeroing errors, sub-maximal effort, etc.)
* Methods you can use to improve test quality.
* Understanding the display and equipment recorder requirements of the ATS/ERS.

Note: Our refresher class is not a repeat of initial spirometry training. It's specifically designed to meet the needs of students who have previously attended a spirometry training program in the past.

Our next in-person Spirometry **Refresher** class will be held:

August 25, 2026

For additional information, visit our web site at: www.DrMcKay.com

Certificates for persons that successfully complete all training requirements will indicate 7.5 contact hours with 0.75 CEUs from the University of Cincinnati.

Interpretation of Spirometry:
Beyond the Numbers

This annual, 1-day comprehensive course is designed for health professionals who want to **master** the art and science of spirometry interpretation. If you've ever wondered why relying on the "three best tracings" leads to errors, or how to spot subtle patterns others miss, this course is for you.

You'll explore **multiple interpretative strategies**, including the 2022 ATS/ERS guidelines, while uncovering their omissions and inconsistencies. We'll also review other approaches (Gold-Hardie, NLHEP, NICE, ACOEM) and the most recent revision to **Dr. McKay's Spirometry Interpretation Algorithm© 2024**, the only comprehensive algorithm consistent with spirometry guidelines.

Through **hands-on practice problems**, you'll learn to identify and understand patterns such as:

Upper, central, lower, early and small airway obstruction
Restrictive and mixed disorders
Artifacts from sub-maximal effort

We'll show you **when to ignore misleading measurements**, how to extract usable data from imperfect maneuvers, and how to recognize poor technique or subject effort. You'll also gain clarity on concepts like **FEV1Q, PRISm, SADI, and dysanaptic patterns**. Practical methods to identify potentially significant change in lung function will be presented. This information is helpful in regards to identifying persons with true lung disease versus variability in the test.

By the end of the day, you'll be equipped to:

Reduce false positives and negatives in diagnosing obstructive, restrictive, and other patterns
Interpret spirometry with confidence - even when results aren't perfect
Apply strategies that improve clinical decision-making

This course is a must for anyone seeking a deeper understanding and practical mastery of spirometry interpretation.

Objectives:

Recognize important components of spirometry standards that impact interpretation of results.
Interpret spirometry graphs as to the type of pattern.
Recognize conditions that affect spirometry results.
Identify errors in test procedures or testing equipment that may affect results.
Recognize factors that cause miss-classification of spirometry patterns (i.e., obstructive to normal, etc.).
Recognize potentially significant change in spirometry testing.
Understand new concepts including **FEV1*Q*** and **PRISm**.

All students attending this program will receive a copy of Dr. McKay's Spirometry Interpretation Algorithm©

Students who materially participate and attend the entire training program will receive a training certificate from the University of Cincinnati (Sponsor & Accreditor) indicating 7.5 Contact hours (0.75 CEUs).

For a complete listing of course content, please visit: www.DrMcKay.com

Next course date is: August 26, 2026

Informal Spirometry Training

Want to improve spirometry training at your workplace? We offer a variety of on-site, informal training programs that vary from 4 - 7 hours in length.

If interested, send an email to info@DrMcKay.com

2026 Respirator Training Schedule

Respirator training dates for calendar year 2026 have set as follows. Class size is limited. If interested, submit a registration request early. Payment is not required to submit a registration request, but space is assigned when payment is received. To submit a request or for additional information, go to: www.DrMcKay.com

Overview of Respiratory Protection:
October 27

Fit Testing Workshop (2-day):
October 28-29

For information about **QualFit™** Software© for qualitative respirator fit testing with sweet and/or bitter agents, go to www.QualFit.net

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To be added to our Newsletter, go to www.DrMcKay.com
There is no cost to subscribe. Your email address is NOT given to any other source. Newsletters are sent 3 - 4 times per year.

Thank you for your continuing support. Students attending our programs help support our graduate training programs and research projects.
We hope to see you at a future training course.

Roy McKay, Ph.D.
Course Director
University of Cincinnati College of Medicine
www.DrMcKay.com

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