

The Occupational Safety & Health Administration (OSHA) has issued criteria for the Respiratory Protection Program regarding respirator fitness determinations. This includes medical evaluations of employees that may be expected to use respirators. This questionnaire is ***mandated*** to provide individual employee information that may affect conditions for respirator usage.

**To the employee:**

**-- IMPORTANT --**

***The validity of your Respiratory Medical Clearance is totally dependent on the completeness and integrity of your responses. Inaccurate or missing information may affect or even invalidate your respiratory medical clearance and respirator assignment.***

**1)** Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at, or review your answers. Your employer must tell you how to return or send this questionnaire to the health care professional who will review it (i.e. *Questionnaire can be returned to supervisor in a sealed envelope).*

**2)** Answer the questions to the best of your knowledge. If you don’t know how to respond to a particular question, put a question mark & feel free to make written comments or questions on the questionnaire. You are welcome to attach a sheet of comments or questions to the questionnaire if you feel further explanation are needed.

**3)** This information is only for respirator evaluation purposes and will only be used for respiratory protection issues.

**4)** The information will be used in combination with other data that is mandated and provided by those responsible for management of your respiratory protection program. This other information includes conditions of respirator usage and work environment as specified on the “*Employee Respirator Usage Assignment Sheet”.*

**5)** The conditions, circumstances, and limitations of your individual respirator usage status can be explained to you by your safety supervisor. This can usually be done during your respirator protection training session.

**6)** Documentation of your surveillance records will be released to your employer in strict compliance with the OSHA & HIPAA regulations. Surveillance exam data is not considered clinically diagnostic. It is for use in company health and safety programs only. Your employer should provide you with a copy of your clearance evaluation.

**7)** A new medical evaluation will be required if conditions for respirator usage and/or significant health status change. There may be potential increased risk factors that may warrant re-evaluation.

**8)**Respirator *Type & Conditions of Usage* are assigned by your Company’s Respiratory Protection Coordinator.

**Thank you for your cooperation and patience.**

When all your information has been reviewed, a clearance to wear specified respirator(s) will be issued to your company’s health & safety manager. You will be given a copy by your Safety Coordinator for your personal records.

If you would like to talk to the reviewing health care professional, you may contact Integrity Safety Services to set up a meeting in person or by phone:

*12389 Reservation Rd. Suite B, Anacortes, WA 98221 Phone (360)299-1208 FAX: (360) 299-1244*

The following information must be provided for every employee who has been selected to use any type of respirator

(*Please Print – Check only boxes that apply to you)*

1**) Your Name**: **Company** / **Location** 2) **Today’s Date**:

3) **SSN or ID #:** 4) **Sex** 5) **Your Height** 6) **Your weight:** 7) **Race:**  a)**White**  b)**Black**

 a) Male  b) Female c) **Hisp**  d) **Other**

7) **Date of Birth:** 8) **Your AGE:** 9) Have you ever worked on a **HAZMAT** team: 10) Do you currently smoke tobacco

 a) **Yes** tobacco or smoked in last Month?  a)**Yes**

8**) Have you been in the military**:  a) **Yes** If “YES”, were you exposed to biological or chemical agents

(either in training or combat)  b) **Yes**

11) **Please check the types of**  a) I **have never worn a respirator** b) Disposable mask (no cartridge)

**respirators you have worn:**  c) Half/Full face filtered  d) Powered filter

 e) Supplied air (airline)  f**) SCBA** (self-contained breathing apparatus)

12) **Have you ever had any of the following problems associated with respirator usage?**

 a) Eye irritation  b) Skin allergies or rashes  c) Anxiety  d) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| ***Please check all that apply to you. Those conditions not checked, do not apply to you.***    **13**) **Have you ever had any 14**) **Have you ever had any of the following 15) Please check any of**  **of the following conditions? cardio related conditions? the following vision**  **conditions that apply**   a) Seizures (fits) – When? \_\_\_\_\_\_\_\_\_   b) Diabetes – Under control  **Yes**   c) Allergic reactions that interfere with breathing   d) Claustrophobia (fear of closed spaces)   e) Trouble smelling odors   f) Asbestosis – When? \_\_\_\_\_\_\_\_\_   g) Asthma – Is this current or being treated?  **Yes**   h) Chronic bronchitis   i) Emphysema   j) Pneumonia   k) Tuberculosis   l) Silicosis   m) Pneumothorax (collapsed lung)   n) Lung cancer   o) Broken ribs   p) Any chest injuries or surgeries   q) Any other lung problems you’ve been told about  a) Heart attack – When? \_\_\_\_\_\_\_\_   b) Stroke – When? \_\_\_\_\_\_\_\_\_\_\_\_   c) Angina – Is it monitored by your Doctor? \_\_\_\_\_\_\_   d) Heart failure – When? \_\_\_\_\_\_\_\_\_\_   e) Swollen legs or feet (not caused by walking)   f) Irregular heart beat (arrhythmia)   h) High blood pressure   i) Frequent chest pain / your doctor treating?   j) Chest pain or tightness during physical activity   k) Any other symptoms that you think might be  related to heart or circulation problems   l) Heart missing or skips beats (last 2 years)   m) Heartburn or indigestion not related to eating   n) Chest pain or tightness that interferes with your job   o) Any other heart problems you’ve been told about   p) **Are any of the conditions you may have checked above being monitored or treated currently by your Doctor**. (please explain)  **to you:**     a) Wear contacts   b) Wear glasses   c) Color blind   d) another eye or  vision problems  you’ve been told  about   e) Loss of vision in  either eye?  **Please explain any current vision problems:**                                    **16) Check any of the following that currently apply to you:**   a) Shortness of breath h) Coughing that wakes you in the morning   b) Shortness of breath when walking fast or up slight incline i) Coughing that occurs when you are lying down   c) Shortness of breath when walking ordinary pace on level j) Coughing up blood in last month   d) Must stop for breath when walking your normal pace on level k) Wheezing   e) Shortness of breath when washing or dressing yourself l) Wheezing that interferes with your job   f) Shortness of breath that interferes with your job m) Chest pain when you breathe deeply  g) Coughing that produces phlegm (thick sputum)n) Any other symptoms that might relate to lung problems    **17)Do you currently take medications for any of the following?**   a) Breathing or lung problems  b) Heart trouble  c) Blood Pressure  d) Seizures (fits)  **18)** **Please note any other things that you take medications for.** (*including “over the counter” medications*):    ***HIGHLY CONFIDENTIAL*** |

*Highly Confidential*

**19) Check any that apply to you:**

a) Back injury b) Back pain

c) Difficulty fully moving your arms and legs d) Pain or stiffness leaning forward or backward at your waist

e) Difficulty fully moving your head up or down f) Difficulty fully moving your head side to side

g) Difficulty bending at your knees h) Difficulty squatting to the ground

i) Difficulty carrying 25 lbs. Or more upstairs or ladder  j) Any muscle or skeletal problem that interferes with

k) Weakness in any of your arms, hands, legs, or feet respirator use

a) Difficulty hearing c) Any other hearing or ear problems (*including injury or ruptured ears*)

b) Wear a hearing aid(s)

**20) Any Ear problems?**

**Release of Surveillance Information**

I consent to the testing requested by my employer. I authorize my respiratory evaluation to be released to my employer in

**strict compliance with OSHA & HIPAA regulations**.

I understand the screening results are for surveillance purposes only, and not to be considered clinically diagnostic.

I understand that this information is to be used only by my employer for required health & safety compliance programs.

I have the right to revoke authorization at any time by notifying in **writing** that my information is not to be released to anyone but myself or who I may designate.

I have read and understand this authorization and hereby  **Consent** **Do not consent**

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Employee)*

**Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Best time to reach you:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***You may be contacted by the healthcare professional with any questions regarding your responses on this questionnaire***

***Note:*** *If this questionnaire was not filled out by the employee please identify who did & why (i.e.* Joe Smith/coworker/can’t read)

# Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you would like to talk with the reviewer, you can *Call Integrity Safety at (360) 299-1208* to make a phone appointment**

***Note: Respirator Type & Conditions of Usage Provided by Company’s Respiratory Protection Coordinator***

**--------------EXAMINER NOTES ONLY BEYOND THIS POINT --------------**

Respirator(s) PFT (% of Pred.) Blood Pressure Vision

**Notes:**

Technician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Manual

Sys:

Dia:\_\_\_\_\_\_\_\_\_\_\_

Sys:

Dia:\_

\_\_\_\_\_\_\_FVC %

\_\_\_\_\_\_\_\_FEV1%

\_\_\_\_\_\_\_FEV1/FVC%

*HIGHLY CONFIDENTIAL*

N95

Air Purifying

Supplied Air

Half Face Full Face

Left 20/\_\_\_\_\_\_\_\_\_\_\_\_\_

Right 20/\_\_\_\_\_\_\_\_\_\_\_\_

Corr.  Uncorr.

**Color** Pass Fail

