



Re: Respirator Fitness Evaluation

Dear Client,

Attached are the forms required to determine an individual's medical fitness to wear a respirator. There are three parts. The employer questionnaire, the employee's questionnaire, and the physician (or licensed health care professional) section.

According to OSHA requirements and regulations, the top portion of the Employer Authorization and Information for Respiratory Evaluation must be completed by the employer before the employee is evaluated at Nevada Occupational Health Center by our physicians. This information is necessary in order for the physician to adequately assess whether the employee can be certified. The employee cannot complete the employer section.

We are also requesting the employee complete all necessary medical history and sections the respiratory prior to arriving at the center, so the reviewing physician can determine if a respiratory physical exam is needed.

Depending on the answers to questions on the questionnaire, a physical exam may not be required. However, it is required that a Physician or Licensed Health Care Professional (PLHCP) review this questionnaire and answer any questions you or your employee may have concerning the questions asked in this questionnaire.

Sincerely,

Jay E. Betz, MD
Medical Director



**EMPLOYER AUTHORIZATION AND INFORMATION FOR RESPIRATORY EVALUATION
(Must be completed by Employer)**

Employer: _____ Employee: _____

Address: _____ Phone: _____

Fax: _____

Check Type of Respirator(s) To Be Used (Check /ALL that apply)

- Air-purifying (non-powered)
- Air-purifying (powered)
- Atmosphere supplying Respirator
- Combination air-line and SCBA
- Continuous-Flow Respirator
- Supplied-Air Respirator
- Open Circuit SCBA Closed Circuit SCBA
- Dust Mask 1/2 Face with Canisters Full Face with Canisters

Make: _____ Model: _____ Cartridge: _____

Special Work Conditions (Check ALL That Apply When Wearing Respirator)

- High Places Enclosed Places
- Temperature Extremes Mostly Cold
- Other: _____

Extent of Usage (Check /ALL that apply)

- On a daily basis / Total Hours _____
- Occasionally- but not more than twice a week / Total Hours _____
- Rarely- or for Emergency situations only / Total Hours _____

Expected Physical Effort Required (Check ALL that apply)

- Light Moderate Heavy

Exposure to Hazardous Materials (Check ALL that apply)

- Arsenic Benzene
- Coke Oven Cotton Seed I Dust
- Cadmium Formaldehyde
- Methylene Chloride Lead
- Textiles Chromium
- Other: _____

Questionnaire will be: HAND CARRIED MAILED OTHER

EVALUATION AUTHORIZATION BY: _____



EMPLOYEE OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Employee: _____ Employer: _____

Can you read? (Circle one) Yes No

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, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

PART A SECTION 1 (MANDATORY)

The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Your height: _____ ft. _____ in.
2. Your weight: _____ lbs.
3. Your job title: _____
4. A phone number where you can be reached by the health care professional who will review this questionnaire (include area code): _____
5. The best time to phone you at this number is: _____ am/ _____ pm.
6. Has your employer told you how to contact the health care professional who will review this questionnaire?
(circle one): Yes No
7. Check the type of respirator you will use (you can check more than one category):
 - a. ___ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
 - b. ___ Other type (for example, half- or full-facepiece type, powered -air purifying, supplied - air, self-contained breathing apparatus).
8. Have you worn a respirator (circle one): Yes No
If "Yes", what type(s): _____

PART A SECTION 2 (MANDATORY)

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator.
(please circle "Yes" or "No")

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?
___ Yes ___ No
2. Have you ever had any of the following conditions?
Yes No a. Seizures (fits)
Yes No b. Diabetes (sugar disease)
Yes No c. Allergic reactions that interfere with your breathing
Yes No d. Claustrophobia (fear of closed-in places)
Yes No e. Trouble smelling odors
3. Have you ever had any of the following pulmonary or lung problems?
Yes No a. Asbestosis
Yes No b. Asthma
Yes No c. Chronic bronchitis
Yes No d. Emphysema
Yes No e. Pneumonia
Yes No f. Tuberculosis
Yes No g. Silicosis
Yes No h. Pneumothorax (collapsed lung)
Yes No i. Lung cancer

- Yes No j. Broken ribs
- Yes No k. Any chest injuries or surgeries
- Yes No l. Any other lung problem that you've been told about

4. Do you currently have any of the following symptoms of pulmonary or lung disease?

- Yes No a. Shortness of breath
- Yes No b. Shortness of breath when walking on level ground or walking up a slight hill or incline
- Yes No c. Shortness of breath when walking with other people at an ordinary pace on level ground
- Yes No d. Have to stop for breath when walking at your own pace on level ground
- Yes No e. Shortness of breath when washing or dressing yourself
- Yes No f. Shortness of breath that interferes with your job
- Yes No g. Coughing that produces phlegm (thick sputum)
- Yes No h. Coughing that wakes you early in the morning
- Yes No i. Coughing that occurs mostly when you are lying down
- Yes No j. Coughing up blood in the last month
- Yes No k. Wheezing
- Yes No l. Wheezing that interferes with your job
- Yes No m. Chest pain when you breathe deeply
- Yes No n. Any other symptoms that you think may be related to lung problems

5. Have you ever had any of the following cardiovascular or heart problems?

- Yes No a. Heart attack
- Yes No b. Stroke
- Yes No c. Angina
- Yes No d. Heart failure
- Yes No e. Swelling in your legs or feet (not caused by walking)
- Yes No f. Heart arrhythmia
- Yes No g. High blood pressure
- Yes No h. Any other heart problem that you've been told about

6. Have you ever had any of the following cardiovascular or heart symptoms?

- Yes No a. Frequent pain or tightness in your chest
- Yes No b. Pain or tightness in your chest during physical activity
- Yes No c. Pain or tightness in your chest that interferes with your job
- Yes No d. In the past two years, have you noticed your heart skipping or missing a beat
- Yes No e. Heartburn or indigestion that is not related to eating
- Yes No f. Any other symptoms that you think might be related to heart or circulation problems

7. Do you currently take medication for any of the following problems?

- Yes No a. Breathing or lung problems
- Yes No b. Heart trouble
- Yes No c. Blood pressure
- Yes No d. Seizures (fits)

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9)

- Yes No a. Eye irritation
- Yes No b. Skin allergies or rashes
- Yes No c. Anxiety
- Yes No d. General weakness or fatigue
- Yes No e. Any other problems that interfere with your use of a respirator?

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

___Yes ___No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently)?

Yes No

11. Do you currently have any of the following vision problems?

- Yes No a. Wear contact lenses
- Yes No b. Wear glasses
- Yes No c. Color blindness
- Yes No d. Any other eye or vision problems

12. Have you ever had an injury to your ears, including a broken ear drum?

Yes No

13. Do you currently have any of the following hearing problems?

- Yes No a. Difficulty hearing
- Yes No b. Wear a hearing aide
- Yes No c. Any other hearing or ear problems

14. Have you ever had a back injury?

Yes No

15. Do you currently have any of the following musculoskeletal problems?

- Yes No a. Weakness in any of your arms, hands, legs, or feet
- Yes No b. Back pain
- Yes No c. Difficulty fully moving your arms and legs
- Yes No d. Pain or stiffness when you lean forward or backward at the waist
- Yes No e. Difficulty fully moving your head up or down
- Yes No f. Difficulty fully moving your head side to side
- Yes No g. Difficulty bending at your knees
- Yes No h. Difficulty squatting to the ground
- Yes No i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.
- Yes No j. Any other muscle or skeletal problem that interferes with using a respirator.

PLHCP / PHYSICIAN SECTION - Check the ONE that applies:

I have reviewed Part A Section 2 of this questionnaire with the employee and I do not recommend that a physical examination be performed.

I have reviewed Part A Section 2 of this questionnaire with the employee and I am recommending that a physical examination be performed.

I have reviewed Part A section 2 of this questionnaire without the employee and I do not recommend that a physical examination be performed.

I have reviewed Part A Section 2 of this question without the employee and I am recommending that a physical examination be performed.

PLHCP Signature

Employee Signature (When Available)

Date