

Hours: Monday-Friday 7:00 am-5:00 pm
490-L Prospect Boulevard • Weis Festival Plaza
Frederick, Maryland 21701
240-566-3001
Fax: 240-566-3003
info@corpohs.com

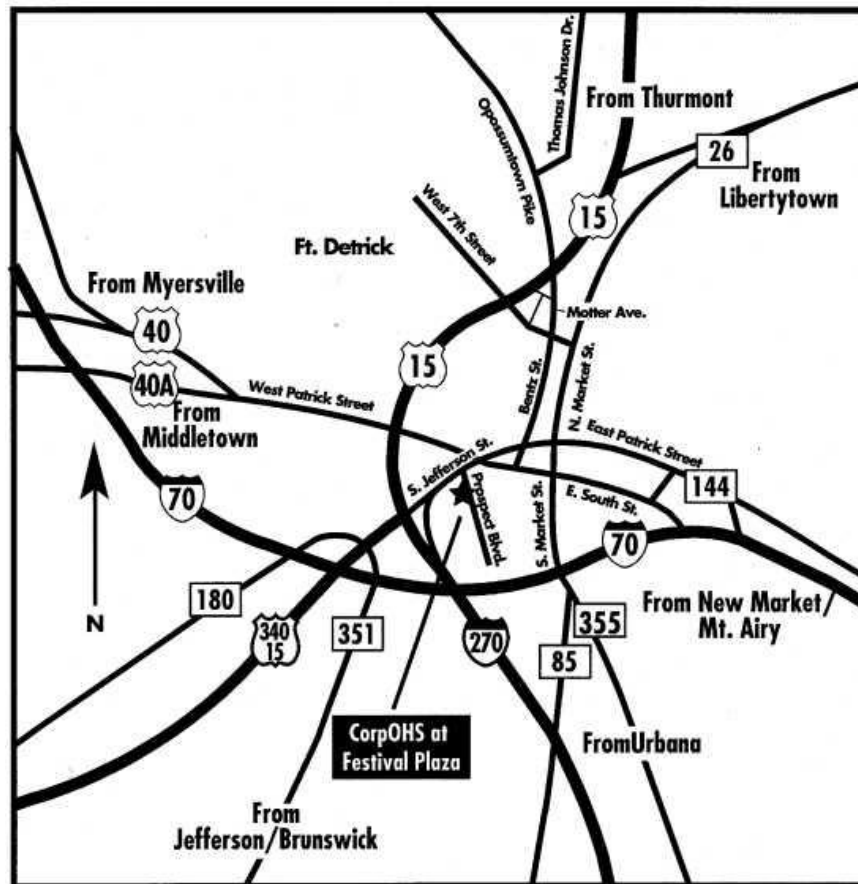
DIRECTIONS

- **From Points North of Frederick:**

Take 15 South to 15/340 (Leesburg/Charleston) exit. Stay in left lane on exit ramp. Turn left at light onto Jefferson Street. Turn right at second light onto Prospect Blvd. Turn right into Weis Festival Plaza. CorpOHS-Frederick is the last office in the first building on the right.

- **From Points South of Frederick:**

From 15 North, exit at Jefferson Street. Take a right at first light onto Prospect Blvd. Turn right into Weis Festival Plaza. CorpOHS-Frederick is the last office in the first building on the right.



Medical History - Healthcare Workers

Frederick Memorial Hospital Employees

Allergies: Latex: Yes No
Medication Allergies: _____
Other Allergies: _____

Last Tetanus booster: _____

Current Medications: _____

Current Physician: _____

Medical Illnesses (check all that apply):

High Blood Pressure Heart Disease Lung Disease Diabetes

Anemia Kidney Disease Seizures Cancer

Stomach or Bowel Disorders: _____

Fractures & Joint Injuries: _____

Other: _____

Surgeries: _____

Social History (Check all that apply):

Tobacco use Cigarettes: packs/day years

Cigars: per day years

Pipe: years

Chew/Snuff: years

Alcohol use Drinks per week

Place an X on the line if you have any of the conditions below now or in the past:
(Caregivers: please comment on positive responses)

Vision

1. Do you use glasses?

For reading

For distant vision

Contacts

2. Are you color blind?

3. Do you have:

Retinal disease

Cataracts

Glaucoma

4. Do you use eye medicine?

5. Have you had eye surgery?

6. Have you had laser exposure?

Heart/Vascular

Do you have:

16. Chest pain on effort

17. High blood pressure

18. Shortness of breath

19. Swelling of ankles

20. Heart murmur

Have you had:

21. Heart attack

22. Stroke

23. Rheumatic fever

24. Heart failure

25. Heart surgery

Hearing

Do you have:

7. Difficulty hearing

8. Ear disease

9. Ringing in the ears

10. Abnormal hearing test

11. Do you use a hearing aid?

12. Have you had ear surgery?

13. Ruptured ear drum?

14. Exposure to gunfire?

15. Wear hearing protection?

Respiratory

Do you have:

26. Chronic cough

27. Asthma

28. Bronchitis

29. Hay fever

30. Emphysema

Have you had:

31. Tuberculosis

32. Lung cancer

33. Lung surgery

34. Silicosis

35. Asbestos

36. Black lung

Liver or Gastrointestinal

- Do you have or have you had:
- 37. Hepatitis
 - 38. Cirrhosis
 - 39. Jaundice
 - 40. Frequent indigestion
 - 41. Ulcer disease
 - 42. Colitis
 - 43. Other intestinal problems
 - 44. Do you have a hernia?
 - 45. Have you had hernia surgery?

Genitourinary

- Do you or have you had:
- 46. Kidney trouble
 - 47. Bladder trouble
 - 48. Kidney stones

Skin

- 49. Do you have eczema?
- 50. Do you have psoriasis?
- 51. Any other skin conditions

Neurologic

- 52. Tremors
 - 53. Dizzy spells
 - 54. Convulsions
 - 55. Paralysis
 - 56. Nerve damage
 - 57. Serious head injury
 - 58. Brain surgery
 - 59. Nervous breakdown
- Are you taking medication for:
- 60. Anxiety or depression
 - 61. Epilepsy
 - 62. Parkinson's disease

Blood, Endocrine

- Have you had:
- 63. Anemia
 - 64. Bleeding problems
 - 65. Hormone problems
 - 66. Diabetes
 - 67. Thyroid problem

Musculoskeletal

- Have you had or do you have:
- 68. Back trouble
 - 69. Disc problems/surgery
 - 70. Shoulder problems/surgery
 - 71. Arm problems/surgery
 - 72. Wrist problems/surgery
 - 73. Hand problems/surgery
 - 74. Hip problems/surgery
 - 75. Leg problems/surgery
 - 76. Knee problems/surgery
 - 77. Ankle problems/surgery
 - 78. Foot problems/surgery
 - 79. Broken bones
 - 80. Numbness, tingling, and/or pain in hands or arms

Communicable Diseases:

- Have you had:
- 81. Chicken pox
 - 82. Measles
 - 83. German Measles
 - 84. Mumps
 - 85. Hepatitis A
 - 86. Hepatitis B
 - 87. Hepatitis C

Vaccine Dates: MMR #1: _____ MMR #2: _____
 Tetanus: _____
 Hepatitis B 1st: _____ 2nd: _____ 3rd: _____
 HepB Antibody Testing: _____ [] Positive [] Negative

Tuberculin (TB) skin test reactor: _____ yes _____ no
 If yes, year of conversion: _____
 If positive, Preventive Drug Treatment: _____ yes _____ no
 If yes, how long did you take medicine: _____
 Last chest x-ray: _____

Have you ever been injured at work? _____ yes _____ no
 If yes, year and type of injury for each injury: _____

Have you ever received worker's compensation: _____ yes _____ no
 If yes, give details: _____

 Employee Signature Date

 Reviewed By Date

OSHA Mandatory Respiratory Medical Evaluation Questionnaire
29 CFR 1910.134

Frederick Memorial Hospital Employees

Can you read: yes no

Your employer must allow you to answer the questionnaire during normal working hours, or at a time 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. Today's Date: ___/___/_____
 2. Your Name: _____
 3. Your Age: _____
 4. Your Social Security #: _____-____-_____
 5. Your Job Title: _____
 6. Your Date of Birth: ___/___/_____
 7. Sex Male Female
 8. Your Height: ___ feet ___ inches
 9. Your Weight: ___ lbs.
 10. Phone # where you can be reached to discuss your answers: (____) ____-_____
 11. The best time to call you at this number: _____ a.m. p.m.
 12. Has your employer told you how to contact the health care professional who will review this questionnaire? yes no
 13. 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).
 14. Have you worn a respirator? 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.

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?
 - a. Seizures (fits) yes no
 - b. Diabetes (sugar disease): yes no
 - c. Trouble smelling odors: yes no
 - d. Claustrophobia (fear of closed-in places) yes no
 - e. Allergic reaction that interfere with your breathing? yes no
3. Have you ever had any of the following pulmonary or lung problems?
 - 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 you've been told about yes no

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
- a. Shortness of breath: yes no
 - b. Shortness of breath when walking fast 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: yes no
5. Have you ever had any of the following cardiovascular or heart problems?
- a. Heart attack: yes no
 - b. Stroke yes no
 - c. Angina yes no
 - d. Swelling in your legs and feet (not caused by walking) yes no
 - e. Heart Failure yes no
 - f. Heart arrhythmia (irregular heart beat) yes no
 - g. High blood pressure yes no
 - h. Any other heart problem that you've been told about: yes no
6. Have you ever had any of the following cardiovascular or heart symptoms?
- a. Frequent pain or tightness in the 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 symptoms that you think may be related to heart or circulation problems: yes no
7. Do you currently take medication for any of the following problems?
- a. Breathing problems yes no
 - b. Heart trouble yes no
 - c. Blood Pressure yes no
 - d. Seizures (fits) yes no
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 box and go to question [] Never Used)
- 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 problem that interferes with your use of a respirator: yes no
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: yes no

Employee Signature

Date

OSHA Mandatory Respirator Medical Evaluation Questionnaire Reviewed by:

PLHCP Signature
f-resphx

Date

N-95 Medical Clearance Form

Frederick Memorial Hospital Employees

Please check Type(s) of Respirator(s) to be used:

- Atmosphere-supplying respirator
- Open-circuit SCBA
- Supplied-air respirator
- Air-purifying (non-powered): N-95 Mask
- Continuous-flow respirator
- Closed circuit SCBA
- Combination air-lined and SCBA
- Air-purifying (powered)

Level of Work Effort: Light Moderate Heavy Strenuous

Extent of Usage:

- On a daily basis
- Occasionally - but more than once a week
- Rarely - or for emergency situations only

Length of Time of Anticipated Effort in Hours: _____

Special Work Considerations: (i.e. high places, temperature, hazardous material, protective clothing, etc.)

Company Safety Representative

Telephone Number

Health Care Provider's Evaluation

Class (check one):

- No restrictions on respirator use
- Some specific use restrictions: Medically cleared for N-95 respirator only
- No respirator use permitted
- Need special frames for glasses if required to wear full-face respirator
- No contact lenses

Restrictions:

FIT TEST TECHNICIAN HAS CONFIRMED THAT FACIAL HAIR IS NOT PRESENT ACROSS RESPIRATOR SEAL AREAS AT THE TIME OF TESTING (OSHA REG 29 CFR 1910.134)

Health Care Provider Signature

Date

f-rclfmh

RESPIRATOR FIT QUANTITATIVE

Frederick Memorial Hospital Employees

Quantitative Respirator Fit Testing will not be performed without a signed Respirator Clearance Form as per OSHA Standard 29 CFR 1910 and 1926.

OHS TECH (initial to verify the following):

_____ Respirator Medical Clearance Report signed by an OHS Caregiver

MEDICAL HISTORY

Please place a check by any of the following that a doctor has ever told you that you have or had:

_____ Claustrophobia _____ Heart Disease _____ Emphysema
_____ Asthma _____ Other Lung Disease

Please explain any of the above that you have checked: _____

Smoking History: _____ Smoker _____ Ex-Smoker _____ Non-Smoker

REVIEW OF SYMPTOMS (Circle Yes or No)

Do you get short of breath at rest? Yes No
Do you get chest pain? Yes No
Do you have medical problems that might interfere with respirator use?
Yes No
If you answered "Yes" to any of the above, please explain: _____

Are you currently taking any medication: Yes No (If yes, list them)

I have been instructed on the Quantitative Fit Testing process.

Employee Signature: _____ Date: ___/___/___

FIT TESTING RESULTS:

- Respirator: Brand and Model Number: 3M#1860 Type: N95
Size: ___ Regular ___ Small
Alternate Brand: Brand and Model Number: _____ Type: _____
- Respirator Fit Test Passed: _____ yes _____ no
 ___ Instructed on donning, removal, and storage
- Reason Fit Test Not Passed: Beard: _____ Other: _____

If not approved for N95 Respirator, then fit test on:
___ Powered Air Purifying Respirator (PAPR) instructions and fitting completed

OHS Tech Signature: _____ Date: ___/___/___

Copy form for OHS chart Original form for employer