

Dear customer,

As your occupational health provider we strive to continue a strong relationship with our valued clients. In an effort to provide these services efficiently we would like to clarify any confusion while filling out the **Respirator Medical Clearance** form for your employees. This information is critical for the caregiver performing the respirator clearance for your employee.

The top of the form is to be completed by you, the employer.

1. The first information that is requested is the type of respirator that the employee is to wear. This is not the brand or model but whether it is **Air Purifying** or **Atmosphere Supplying**. There are selections under each of those categories as well.
 - A) An **Air Purifying Respirator** is a respirator with an air-purifying filter, cartridge, or canister that removes specific air contaminants by passing ambient air through the air purifying element. Air Purifying Respirators are either Negative Pressure (half face or full face) and N95 Particulate Respirator. Canister respirators protect against certain fumes or gases. N95 Respirators capture particles but do not protect against fumes or gases. Positive pressure air purifying respirators include PAPR's. A PAPR (full face or hood) is a hood or full face with a hose that connects to a power pack worn on the person.
 - B) An **Atmosphere Supplying Respirator** is a breathing device that supplies the wearer with air from a source that is separate from the ambient air, such as from an air tank. These include Atmosphere Supplying types are Airline (continuous flow), SCBA (positive pressure, pressure demand) open circuit or closed circuit (rebreather) and Combined (airline/SCBA). In open circuit SCBA's the exhales air is discarded. This is the typical SCBA worn by fire fighters. In closed circuit SCBA's the exhales air is recirculated to provide longer use times. Airline (continuous flow) Respirators are air-supplied respirators that make use of a hose to deliver safe air from a stationary source of compressed air. Self-Contained Breathing Apparatus, SCBA, consists of a wearable clean-air supply pack.
2. Level of Work Effort. Level of work the employee will be doing while wearing the respirator. Choices are Light, Moderate, Heavy and Strenuous.
3. Extent of Usage. Will the employee be wearing the respirator on a daily basis? Occasionally, but more then once a week? Or rarely - or For emergency situations only?

4. Length of Time of Anticipated Effort in Hours. This is the length of time that the employee would be expected to wear the respirator.
5. Special Work Considerations. Complete this section if the employee would be wearing the respirator in high places, excessive temperature, hazardous material, wearing protective clothing etc.
6. The final step is to sign the form. The line is titled Company Safety Representative with phone number. This should be who has completed the form.

The rest of the form is for the care provider to complete. This form should accompany the **OSHA Mandatory Respirator Medical Evaluation Questionnaire**, which is to be filled out by your employee.

If you are mailing these forms into one of our facilities, please mail to the contact below for each facility, or if you have any questions, please feel free to contact them.

CorpOHS – Frederick

490-L Prospect Blvd
Frederick, MD 21701
Appointments: 240-566-3001

Laurie Gourley-Benfield
Customer Care Manager
240-566-3818

Carroll Occupational Health

700 Corporate Center Court, Suite A
Westminster, MD 21157
Appointments: 410-871-0470

Jaime Etzel
Customer Care Coordinator
410-848-7156

Thank you for your attention in this matter if it applies to your organization.

Your workplace and your employees are our only business.

Name: _____ Date: _____ Company Name: _____

Respirator Med Clearance Form

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

Air Purifying:

- Negative Pressure (half face or full face)
- PAPR (full face or hood)
- N95 Particulate Respirator

Atmosphere Supplying:

- Airline (continuous flow)
- SCBA (positive pressure, pressure demand)
 - open circuit
 - closed circuit (rebreather)
- Combined (airline/SCBA)

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
- 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

OSHA Mandatory Respirator Medical Evaluation Questionnaire
29 CFR 1910.134

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A do not require a medical examination.

To the employee: 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 (circle one) Male Female	8. Your Height _____ Ft. _____ in.	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

11. 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).

12. 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) <input type="checkbox"/> yes <input type="checkbox"/> no	b. Diabetes (sugar disease): <input type="checkbox"/> yes <input type="checkbox"/> no	c. Trouble smelling odors: <input type="checkbox"/> yes <input type="checkbox"/> no
d. Claustrophobia (fear of closed-in places) <input type="checkbox"/> yes <input type="checkbox"/> no	e. Allergic reaction that interfere with your breathing? <input type="checkbox"/> yes <input type="checkbox"/> no	

3. Have you *ever had* any of the following pulmonary or lung problems?

a. Asbestosis <input type="checkbox"/> yes <input type="checkbox"/> no	b. Asthma <input type="checkbox"/> yes <input type="checkbox"/> no	c. Chronic bronchitis <input type="checkbox"/> yes <input type="checkbox"/> no
d. Emphysema <input type="checkbox"/> yes <input type="checkbox"/> no	e. Pneumonia <input type="checkbox"/> yes <input type="checkbox"/> no	f. Tuberculosis <input type="checkbox"/> yes <input type="checkbox"/> no
g. Silicosis <input type="checkbox"/> yes <input type="checkbox"/> no	h. Pneumothorax (collapsed lung) <input type="checkbox"/> yes <input type="checkbox"/> no	i. Lung cancer <input type="checkbox"/> yes <input type="checkbox"/> no
j. Broken ribs <input type="checkbox"/> yes <input type="checkbox"/> no	k. Any chest injuries or surgeries <input type="checkbox"/> yes <input type="checkbox"/> no	l. Any other lung problem you've been told about <input type="checkbox"/> yes <input type="checkbox"/> no

2. 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 <input type="checkbox"/> yes <input type="checkbox"/> no	b. Stroke: <input type="checkbox"/> yes <input type="checkbox"/> no
c. Angina <input type="checkbox"/> yes <input type="checkbox"/> no	d. Swelling in your legs and feet (not caused by walking) <input type="checkbox"/> yes <input type="checkbox"/> no
e. Heart Failure <input type="checkbox"/> yes <input type="checkbox"/> no	f. Heart arrhythmia (irregular heart beat) <input type="checkbox"/> yes <input type="checkbox"/> no
g. High blood pressure <input type="checkbox"/> yes <input type="checkbox"/> no	h. Any other heart problem that you've been told about: <input type="checkbox"/> yes <input type="checkbox"/> 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?

Breathing problems <input type="checkbox"/> yes <input type="checkbox"/> no	Heart trouble <input type="checkbox"/> yes <input type="checkbox"/> no	Blood Pressure <input type="checkbox"/> yes <input type="checkbox"/> no	Seizures (fits) <input type="checkbox"/> yes <input type="checkbox"/> no
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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 9.

a. Eye Irritation: <input type="checkbox"/> yes <input type="checkbox"/> no	b. Skin allergies or rashes: <input type="checkbox"/> yes <input type="checkbox"/> no
c. Anxiety <input type="checkbox"/> yes <input type="checkbox"/> no	d. General weakness or fatigue: <input type="checkbox"/> yes <input type="checkbox"/> 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

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a 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

13. Do you *currently* have any of the following vision problems:

a. Wear contact lenses: <input type="checkbox"/> yes <input type="checkbox"/> no	b. Wear glasses: <input type="checkbox"/> yes <input type="checkbox"/> no
c. Color blind: <input type="checkbox"/> yes <input type="checkbox"/> no	d. Any other eye or vision problem: <input type="checkbox"/> yes <input type="checkbox"/> no

12. Have you *ever had* an injury to you ears, including a broken eardrum: yes no

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

- a. Difficulty hearing: yes no
- b. Wear a hearing aid: yes no
- c. Any other hearing or ear problem: yes no

14. Have you *ever had* a back injury: yes no

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

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

Part B

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 ft) or in a place that has lower than normal amounts of oxygen: yes no

If "yes" do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: yes no

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: yes no

If "yes" name the chemicals if you know them:

3. Have you ever worked with any of the materials, or under any of the conditions listed below:

a. Asbestos: <input type="checkbox"/> yes <input type="checkbox"/> no	b. Silica: <input type="checkbox"/> yes <input type="checkbox"/> no	c. Tungsten/Cobalt: <input type="checkbox"/> yes <input type="checkbox"/> no
d. Beryllium: <input type="checkbox"/> yes <input type="checkbox"/> no	e. Aluminum <input type="checkbox"/> yes <input type="checkbox"/> no	f. Coal: <input type="checkbox"/> yes <input type="checkbox"/> no
g. Iron: <input type="checkbox"/> yes <input type="checkbox"/> no	h. Tin: <input type="checkbox"/> yes <input type="checkbox"/> no	i. Dusty environments: <input type="checkbox"/> yes <input type="checkbox"/> no

- j. Any other hazardous exposures: yes no

If "yes" describe the exposure:

3. List any second jobs or side businesses you have:

4. List your previous occupations:

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5. List your current & previous hobbies:

7. Have you been in the military service? yes no

If "yes" describe these exposures:

8. Have you ever worked on a HAZMAT team? yes no

9. Other than the medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): yes no

If "yes" name the medications if you know them:

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters <input type="checkbox"/> yes <input type="checkbox"/> no	b. Canisters (e.g. gas masks) <input type="checkbox"/> yes <input type="checkbox"/> no	c. Cartridges <input type="checkbox"/> yes <input type="checkbox"/> no
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11. How often are you expected to use the respirator:

a. Escape only; no rescue <input type="checkbox"/> yes <input type="checkbox"/> no	b. Emergency rescue only <input type="checkbox"/> yes <input type="checkbox"/> no
c. Less than 5 hours per week <input type="checkbox"/> yes <input type="checkbox"/> no	d. Less than 2 hours per day <input type="checkbox"/> yes <input type="checkbox"/> no
e. 2 to 4 hours per day <input type="checkbox"/> yes <input type="checkbox"/> no	f. Over 4 hours per day <input type="checkbox"/> yes <input type="checkbox"/> no

12. During the period you are using the respirator(s), is your work effort:
a. *Light* (less than 200 kcal per hour): yes no

If "yes", how long does this period last during the average shift

_____ hours _____ minutes

Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.

b. *Moderate* (200 to 350 kcal per hour) yes no

If "yes", how long does this period last during the average shift

_____ hours _____ minutes

Examples of moderate work effort are *sitting* while nailing or filing, driving a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. Heavy (above 350 kcal per hour): yes no
If "yes", how long does this period last during the average shift
_____ hours _____ minutes

Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.)

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using the respirator: yes no

If "yes" describe this protective clothing and/or equipment:

14 Will you be working under hot conditions (temperature exceeding 77 degrees F) yes no

15. Will you be working under humid conditions: yes no

16. Describe the work you'll be doing while you're using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (e.g., confined spaces, life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s)

Name of toxic substance - #1
Estimated maximum exposure level per shift
Duration of exposure per shift:

Name of toxic substance - #2
Estimated maximum exposure level per shift
Duration of exposure per shift

Name of toxic substance - #3
Estimated maximum exposure level per shift
Duration of exposure per shift

Name of toxic substance - #4
Estimated maximum exposure level per shift
Duration of exposure per shift

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well being of others (e.g. rescue, security)

OSHA Mandatory Respirator Medical Evaluation Questionnaire Reviewed by:

Healthcare Provider Signature

Date