Campus Facilities Respirator Clearance Request

Employee Name _____

Employee I.D. _____

Employee Phone # (_____)-_____-_____

Department Name _____

Department Contact _____

Department Contact Email Address _____

Department Contact Phone # (_____)-_____-_____

Type of Respirator to by worn: ☐ N95 ☐ Half Mask ☐ Full Mask ☐ PAPR

Work Level: ☐ Light ☐ Moderate ☐ Heavy ☐ Very Heavy

Work Conditions – check all that apply:

- ☐ Emergency or escape only ☐ Intermittent use
- ☐ High temperature ☐ Continuous use
- ☐ High humidity ☐ Work can be paced
- ☐ Awkward positions ☐ Confined spaces
- ☐ Must be able to see and hear emergency signals
- ☐ Protective clothing: ___light ___heavy

Instructions:

1. Fill out Campus Facilities Respirator Clearance Request.
2. Have employees fill out Campus Facilities Respirator Clearance Questionnaire and put in sealed envelope.
3. Departmental contact will hand deliver the Questionnaire and Respirator Clearance Request form to Dr. Szewczyk's office:

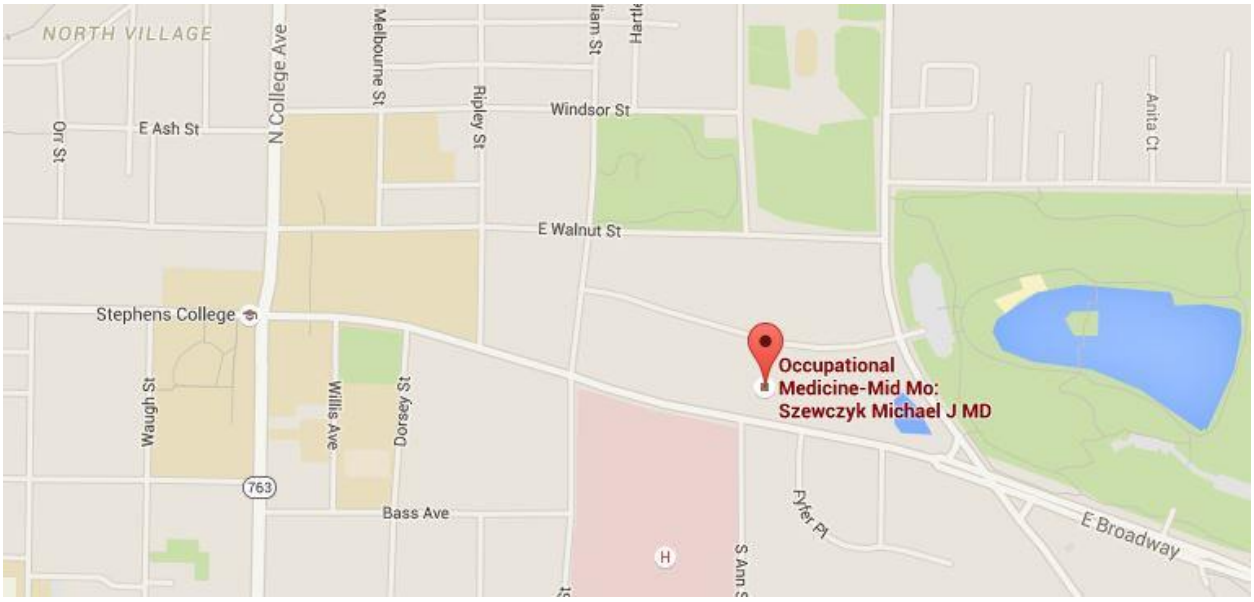
   Occupational Medicine of Mid Missouri
   1701 East Broadway, Suite 204
   Phone: 573-815-2667
   Fax: 573-815-2666

Signature of Departmental Contact_____

Date_____

Note: If a medical examination is warranted by the results of the questionnaire, Dr. Szewczyk's office will contact the departmental contact to schedule any needed examinations or follow ups.

Location of Occupational Medicine of Mid Missouri



Enter Plaza 3 through the South Entrance on the first floor and follow the signs or park on the top floor (D) of the parking garage on the North Side of building and take bridge, entering on the third floor of the Plaza 3.

Campus Facilities

OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
Appendix C to §1910.134 (Part A, Section 1 and 2)

To the employee:
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. Today's Date: _____

2. Your Name: _____

3. Your age: _____ (to the nearest year)

4. Sex: ☐ Male ☐ Female

5. Your height: _____ft. _____ in.

6. Your weight: _____ lbs.

7. Your job title: _____

8. A phone number where you can be reached by the Health Care Professional who reviews this questionnaire: (_____)_____-_____
   area code

9. The best time to phone you at this number: _____

10. 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 (simple/dusk mask, 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 ever worn a respirator? (check 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 check "yes" or "no").

	Yes	No
1. Do you ***currently*** smoke tobacco, or have you smoked tobacco in the last month:	☐	☐
2. Have you ***ever*** had any of the following conditions?		
a. Seizures (fits) ……	☐	☐
b. Diabetes (sugar disease) ……..	☐	☐
c. Allergic reactions that interfere with your breathing ……	☐	☐
d. Claustrophobia (fear of closed-in places) ……	☐	☐
e. Trouble smelling odors ……..	☐	☐
3. Have you ***ever*** had any of the following pulmonary or lung problems? (even as a child)		
a. Asbestosis: ……	☐	☐
b. Asthma: ……..	☐	☐
c. Chronic bronchitis: ……..	☐	☐
d. Emphysema: ……..	☐	☐
e. Pneumonia: ……..	☐	☐
f. Tuberculosis: ……	☐	☐
g. Silicosis: ……..	☐	☐
h. Pneumothorax (collapsed lung): ……	☐	☐
i. Lung cancer: ……..	☐	☐
j. Broken ribs: ……..	☐	☐
k. Any chest injuries or surgeries: ……..	☐	☐
l. Any other lung problem that you have been told about: ……	☐	☐
4. Do you ***currently*** have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath: ……	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: …	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground: ……..	☐	☐
d. Have to stop for breath when walking at your own pace on level ground: ……..	☐	☐
e. Shortness of breath when washing or dressing yourself: ……..	☐	☐
f. Shortness of breath that interferes with your job: ……	☐	☐
g. Coughing that produces phlegm (thick sputum): ……	☐	☐
h. Coughing that wakes you early in the morning: ……..	☐	☐
i. Coughing that occurs mostly when you are lying down: ……	☐	☐
j. Coughing up blood in the last month: ……	☐	☐
k. Wheezing: ……..	☐	☐
l. Wheezing that interferes with your job: ……..	☐	☐
m. Chest pain when you breathe deeply: ……	☐	☐
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?		
a. Heart attack: ……	☐	☐
b. Stroke: ……..	☐	☐
c. Angina: ……..	☐	☐
d. Heart failure: ……	☐	☐
e. Swelling in your legs or feet (not caused by walking): ……..	☐	☐
f. Heart arrhythmia (heart beating irregularly): ……..	☐	☐
g. High blood pressure: ……..	☐	☐
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 your chest: ……	☐	☐
b. Pain or tightness in your chest during physical activity: ……..	☐	☐
c. Pain or tightness in your chest that interferes with your job: ……	☐	☐
d. In the past two years, have you noticed your heart skipping or missing a beat: ……..	☐	☐
e. Heartburn or indigestion that is not related to eating: …….	☐	☐
f. Any other symptom that you think may be related to heart or circulation problems: ……	☐	☐
7. Do you ***currently*** take any medication for any of the following problems?		
a. Breathing or lung problems: ……..	☐	☐
b. Heart trouble: …….	☐	☐
c. Blood pressure: ……	☐	☐
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) Never used.	☐	
a. Eye irritation: ……	☐	☐
b. Skin allergies or rashes: ……	☐	☐
c. Anxiety: ……	☐	☐
d. General weakness or fatigue: ……	☐	☐
e. Any other problem that interferes 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: ……...	☐	☐

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece 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): ……	☐	☐
11. Do you ***currently*** have any of the following vision problems?		
a. Wear contact lenses: ……..	☐	☐
b. Wear glasses: …….	☐	☐
c. Color blind: ……	☐	☐
d. Any other eye or vision problem: ……..	☐	☐
12. Have you ***ever had*** an injury to your ears, including a broken eardrum?: ……	☐	☐
13. Have you ***ever*** had a back injury: …….	☐	☐
14. Do you ***currently*** have any of the following musculoskeletal problems?		
a. Weakness in any of your arms, hands, legs, or feet: ……..	☐	☐
b. Back pain: ……..	☐	☐
c. Difficulty fully moving your arms and legs: …….	☐	☐
d. Pain or stiffness when you lean forward or backward at the 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. Climbing a flight of stairs or a ladder carrying more than 25 lbs.: ……	☐	☐
j. Any other muscle or skeletal problem that interferes with using a respirator: ……..	☐	☐

(Please describe): _____

_____

	Yes	No
15. Do you ***currently*** have any of the following hearing problems?		
a. Difficulty hearing: ……	☐	☐
b. Wear a hearing aid: ……..	☐	☐
c. Any other hearing or ear problem: ……	☐	☐

Please describe: _____

Part B. The following questions have been added to assist the healthcare provider who will be reviewing this questionnaire to determine your ability to wear a respirator.

1.	At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (for example insecticides, weed killers, solvents, stripping chemicals, dangerous gases, fumes or dust), or have you come into skin contact with hazardous chemicals.?…… ……..	☐	☐

If "yes," please name the chemical(s): _____

_____

2.	Have you ever worked with any of the materials, or under any of the conditions listed below:		
	a. Asbestos: ……	☐	☐
	b. Silica (*e.g.*, in sandblasting): ……	☐	☐
	c. Tungsten/cobalt (*e.g.*, grinding or welding this material): ……	☐	☐
	d. Beryllium: ……	☐	☐
	e. Aluminum: ……	☐	☐
	f. Coal (for example, mining): ……..	☐	☐
	g. Iron: ……	☐	☐
	h. Tin: ……	☐	☐
	i. Dusty environments: ……	☐	☐
	j. Any other hazardous exposures: ……	☐	☐
	Have you ever performed the following work: (Circle all that apply)	☐	☐

quarry	foundry	pottery/brick plant	textile mill
refinery	chemical plant	insulation installation/removal	steel/coke mill
shipyard	painting	sanding / sandblasting	spraying
farming	fertilizer plant	plating, acid bath	degreasing machine

If “yes” to any of the above, describe these exposures: _____

_____

_____

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

_____

4. List your previous occupations: _____

_____

5. List your current and previous hobbies: _____

_____

6.	Other than 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): ……	☐	☐

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

_____

	Yes	No
7. Have you been in the military services? ……..	☐	☐
If "yes," were you exposed to biological or chemical agents (either in training or combat): …….	☐	☐
8. Have you ever worked on a HAZMAT team? …….	☐	☐
9. Will you be using any of the following items with your respirator(s)?		
a. HEPA Filters: ……	☐	☐
b. Canisters (for example, gas masks): ……..	☐	☐
c. Cartridges: ……	☐	☐
10. How often are you expected to use the respirator(s)?		
a. Escape only (no rescue): …….	☐	☐
b. Emergency rescue only: …….	☐	☐
c. Less than 5 hours **per week**: …….	☐	☐
d. Less than 2 hours **per day**: ……..	☐	☐
e. 2 to 4 hours **per day**…….	☐	☐
d. Over 4 hours **per day** ……	☐	☐
11. What type of work will you be performing while wearing a respirator?		
a. Light (writing, typing, light assembly / production)…….	☐	☐
If yes, for how long during the average shift: _____hours, _____minutes		
b. Moderate (urban driving truck or bus, drilling, nailing, lifting 35 #'s at trunk level)……	☐	☐
If yes, for how long during the average shift: _____hours, _____minutes		
c. Heavy (lift and carrying 50 lbs., shoveling, climbing stairs with load, repetitive stacking)……	☐	☐
If yes, for how long during the average shift: _____hours, _____minutes		
12. While using the respirator, will you be wearing protective clothing and/or equipment? ……	☐	☐
If "yes," describe _____		
13. Will you be working under hot or humid conditions (temperature exceeding 85° F): ……	☐	☐
14. Do you have any specific conditions that may affect your ability to wear a respirator? ……	☐	☐
Please list: _____		

15. Describe the work you'll do while wearing the respirator and any hazardous conditions you may encounter: _____

_____

16. Will you be wearing your respirator in confined spaces or with life-threatening gases? ……..	☐	☐

Describe, if known, the toxic substances you'll be exposed to while wearing your respirator(s):

Name of first toxic substance: _____

Exposure duration: _____ Exposure level: _____

Name of second toxic substance: _____

Exposure duration: _____ Exposure level: _____

Name of third toxic substance: _____

Exposure duration: _____ Exposure level: _____

List additional substances on the back of this form.

17. Describe any special responsibilities you will have while wearing the respirator that may affect the safety and well-being of others: _____

_____

Reviewed by:_____ Date:_____