401 Matthew Street
Marietta, OH 45750
P: (740) 374-9954
F: (740) 374-7230

807 Farson Street Suite 101
Belpre, OH 45714
P: (740) 401-0090
F: (740) 401-0258

RESPIRATOR TESTING

Patient Name:______________________________ **Date:**______________

Company/Local Union #:______________________________

Social Security #:______________________ **Date of Birth:**______________

I consent to the release of the findings of this test to my employer, and if required, to the owner or operator of the facility at which I am to be considered for employment or continued employment.

______________________________ ______________________________
Signature **Date**

MEDICAL RELEASE TO WEAR RESPIRATOR

☐ **This employee has no apparent abnormal findings or medical history responses that would prevent him/her from wearing a respirator.**

☐ **This employee has significant abnormal medical findings or medical history responses, which prevent him/her from wearing a respirator.**

☐ **This employee has significant abnormal medical findings or medical history responses, which will require approval from his/her attending physician stating he/she is able to wear a respirator.**

Comments:______________________________

______________________________ ______________________________
Occupational Health Technician **Date** **Medical Director** **Date**

☐ **Written medical clearance provided on** ______________
Date

Approved to wear respirator ☐ **Yes** ☐ **No**

____
Medical Director **Date**

RESPIRATOR FIT TESTING

❐ **Fit Testing Not Requested**

Test Type: ❐ **Saccharin** ❐ **Isoamyl Acetate** ❐ **Portacount**
Mask Type: ❐ **Single Use** ❐ **½ Face** ❐ **Full Face**
❐ **Self Contained Breathing Apparatus** ❐ **Other**______________

Brand______________ **Model**______________ **Size**______________ ☐ **PASS** ☐ **FAIL**

Brand______________ **Model**______________ **Size**______________ ☐ **PASS** ☐ **FAIL**

Brand______________ **Model**______________ **Size**______________ ☐ **PASS** ☐ **FAIL**

Brand______________ **Model**______________ **Size**______________ ☐ **PASS** ☐ **FAIL**

____
Occupational Health Technician **Date**

Location of Testing: **ON SITE** **IN OFFICE**
(circle one)

The measurement provided by this method is an assessment of respirator fit during a fit test only. Respirator fit at other times will vary. The fit factor value is not intended for use in estimating an individual's actual exposure to hazardous substances.

OSHA Respirator Medical Evaluation Questionnaire

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. Your Name:____ Date:______________________________
2. Address:____
3. City:____ State:___________________ Zip:___________________
4. Your age (to nearest year):_________ Date of Birth:_________________ SS#_________________________
5. Sex (circle one): Male Female
6. Your Height: ___________ft. ___________in. Blood Pressure: __________ Pulse: __________
   Repeat BP: __________
7. Your Weight: ________________________lbs.
8. Your Job Title: ____
9. A phone number where you can be reached by the health care professional who reviews this questionnaire (Include Area Code):____
10. The best time to phone you at this number:____
11. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): YES NO
12. 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-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
13. Have you worn a respirator (circle one): Yes No
    If "yes", what type (s):____

Name:____ Date:______________________________

Part A. Section 2. (Mandatory) Questions 1 through 9 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?
   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: 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 problems that 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 waked you early in the morning: Yes No
   i. Coughing that occurs mostly when you are laying 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

Name:____ Date:______________________________

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. Heart failure: Yes No
   e. Swelling in your legs or feet (not caused by walking): Yes No
   f. Heart arrhythmia (heart beating irregularly): Yes No
   g. High blood pressure: Yes No
   h. Any other heart problem that you have 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: 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 a beat: Yes No
   e. Heartburn or indigestion that is not related to eating: Yes No
   f. Any other 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 or lung 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 had any of the following problems? (If you've never used a respirator, check the following space and go to question 9):
   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

Name:____ Date:_____________________________

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)? Yes No

11. Do you currently have any of the following vision problems?
    a. Wear contact lenses Yes No
    b. Wear glasses Yes No
    c. Color Blind Yes No
    d. Any other eye or vision problem Yes No

12. Have you ever had an injury to your 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 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 Yes No