CARROLL OCCUPATIONAL HEALTH
Affiliated with Carroll Hospital Center

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) or 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. 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 exhaled air is discarded. This is the typical SCBA worn by fire fighters. In closed circuit SCBA's, the exhaled 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. A 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 than 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 temperatures, hazardous materials, 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 care provider to complete. This form should accompany the **OSHA Mandatory Respirator Medical Evaluation Questionnaire,** which is to be filled out by the employee.

Bring these completed forms to your clinic visit. If you are mailing these forms mail them to the appropriate contact below:

Frederick Health Employer Solutions Frederick:
Practice Manager
490 Prospect Blvd Suite L
Frederick MD 21701

Frederick Health Employer Solutions Howard:
Practice Manager
7165 Columbia Gateway Drive Suite G
Columbia MD 21046

Carroll Occupational Health:
Practice Manager
700 Corporate Center Court Suite B
Westminster MD 21157

Your Workplace and Your Employees are Our Only Business.

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.)

_____

_____ _____
Safety Representative/Supervisor 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

f-respcl

Respirator Questionnaire

OSHA Mandatory Respirator Medical Evaluation Questionnaire
29 CFR 1910.134

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 Job Title: _____ 5. Your Date of Birth: ___/___/_____
6. Sex [ ] Male [ ] Female 7. Your Height: ___ feet ___ inches
8. Your Weight: ____ lbs.
9. Phone # where you can be reached to discuss your answers:(_____) _____-_____
10. The best time to call you at this number:
_____ [ ] a.m. [ ] p.m.
11. Has your employer told you how to contact the health care professional who will review this questionnaire? [ ] 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-facepiece type, powered-air purifying supplied air, self-contained breathing apparatus).
13. 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

Respirator Questionnaire

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 9. [ ] 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

Respirator Questionnaire

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
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 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: [ ] yes [ ] no
    b. Back pain [ ] yes [ ] no
    c. Difficulty fully moving you arms & 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

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:

   _____
   _____

Respirator Questionnaire

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

a.	Asbestos:	[ ] yes	[ ] no
b.	Silica:	[ ] yes	[ ] no
c.	Tungsten/Cobalt:	[ ] yes	[ ] no
d.	Beryllium:	[ ] yes	[ ] no
e.	Aluminum:	[ ] yes	[ ] no
f.	Coal:	[ ] yes	[ ] no
g.	Iron:	[ ] yes	[ ] no
h.	Tin:	[ ] yes	[ ] no
i.	Dusty environments:	[ ] yes	[ ] no
j.	Any other hazardous exposures:	[ ] yes	[ ] no

If 'yes' describe the exposure:

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

5. List your previous occupations:

6. 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:

Respirator Questionnaire

10. Will you be using any of the following items with your respirator(s)?
    a. HEPA Filters [ ] yes [ ] no
    b. Canisters (e.g. gas masks) [ ] yes [ ] no
    c. Cartridges [ ] yes [ ] no
11. How often are you expected to use the respirator:
    a. Escape only; no rescue [ ] yes [ ] no
    b. Emergency rescue only [ ] yes [ ] no
    c. Less than 5 hours per week [ ] yes [ ] no
    d. Less than 2 hours per day [ ] yes [ ] no
    e. 2 to 4 hours per day [ ] yes [ ] no
    f. Over 4 hours per day [ ] yes [ ] 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):

Respirator Questionnaire

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)

_____ _____
Employee Signature Date

OSHA Mandatory Respirator Medical Evaluation Questionnaire Reviewed by:

_____ _____
PLHCP Signature Date