

Medical Clearance for Respirator Use Instructions

- I. Employer gives employee a copy of the mandatory questionnaire (on company time per the standard). Also provides a business envelope addresses to the examining clinic, along with phone number and the name of the PLHCP(s) at the clinic which the employee may call if any questions or concerns develop.
- II. Employer completes the “*Employer’s Authorization for Medical Evaluation for Respirator Use*” form and sends it with the completed questionnaire to the clinic.
- III. The employer also provides the clinic with a copy of the written respiratory protection program.**
- IV. Employer sends the completed questionnaire and authorization in closed envelope to the PLHCP (the employer is not allowed to read the completed questionnaire per the standard for medical confidentiality).
- V. PLHCP reviews the employer’s written respiratory protection program.
- VI. PLHCP reviews the questionnaire and information in the authorization form and makes a clinical assessment of ability to use respirator(s).
- VII. PLHCP assessment may be:
 - a. Medically suitable for respirator use
 - b. Needs further evaluation to determine suitability for employee using a respirator either by the paramedical provider or by the physician.
- VIII. If further evaluation is necessary, the PLHCP schedules (or notifies the employer to schedule) the employee for further examinations with the appropriate PLHCP.
- IX. Further evaluation conducted which may be included:
 - a. elaboration on the medical questionnaire
 - b. vital signs determination
 - c. physical examination
 - d. pulmonary function tests (PFT’s)
 - e. chest x-ray
 - f. stress EKG
 - g. specialist consultation
- X. Medical suitability determined following above evaluation including types of respirators, conditions of use, limitations or restrictions on use and future re-examinations as needed.
- XI. PLHCP provides written determination to both the employee and employer



MEDICAL EVALUATION FOR RESPIRATOR USE
(OSHA MANDATORY QUESTIONNAIRE)
Reference 29CFR1910.134, Appendix C

To the employee: Can you read? 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).

Employee Name Social Security Number Age Today's Date
Male Female Sex Height Weight Job Title

Phone number where the health care professional who reviews this questionnaire can call you (include the Area Code):
Best time to phone you at this number am or pm (circle one)

Has your employer told you how to contact the health care professional who will review this questionnaire (check one): Yes No

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 (Example, half- / full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you 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").

- 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?
Seizures (fits) Yes No
Diabetes (sugar disease) Yes No
Trouble smelling odors Yes No
Claustrophobia (fear of closed-in places) Yes No
Allergic reactions that interfere with your breathing Yes No
3. Have you ever had any of the following pulmonary or lung problems?
Asbestosis Yes No
Asthma Yes No
Chronic bronchitis Yes No
Emphysema Yes No
Pneumonia Yes No
Tuberculosis Yes No
Silicosis Yes No
Pneumothorax (collapsed lung) Yes No

DECATUR
1615 Kathy Lane, SW
Decatur, AL 35603
Phone: 256/353-4325

HUNTSVILLE
1963 Memorial Parkway
Huntsville, AL 35801
Phone: 256/265-7000

MADISON
9238 Madison Blvd., Ste. 200
Madison, AL 35758
Phone: 256/774-7300

WELLNESS SERVICES
6767 Old Madison Pike # 400
Huntsville, AL 35806
Phone: 256/922-6699



MEDICAL EVALUATION FOR RESPIRATOR USE (OSHA MANDATORY QUESTIONNAIRE)

Reference 29CFR1910.134, Appendix C

(Continued from page 1) Have you ever had any of the following pulmonary or lung problems?

- Lung cancer Yes No
- Broken ribs Yes No
- Any chest injuries or surgeries Yes No
- Any other lung problem that you've been told about Yes No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

- Shortness of breath Yes No
- Shortness of breath when walking fast on level ground or walking up a slight hill or incline Yes No
- Shortness of breath when walking at your own pace on level ground Yes No
- Have to stop for breath when walking with other people at an ordinary pace on level ground Yes No
- Shortness of breath when washing or dressing yourself Yes No
- Shortness of breath that interferes with your job Yes No
- Coughing that produces phlegm (thick sputum) Yes No
- Coughing that wakes you early in the morning Yes No
- Coughing that occurs mostly when you are lying down Yes No
- Coughing up blood in the last month Yes No
- Wheezing Yes No
- Wheezing that interferes with your job Yes No
- Chest pain when you breathe deeply Yes No
- 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?

- Heart attack Yes No
- Stroke Yes No
- Angina Yes No
- Heart Failure Yes No
- Swelling in your legs or feet (not caused by walking) Yes No
- Heart arrhythmia (heart beating irregularly) Yes No
- High blood pressure Yes No
- 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?

- Frequent pain or tightness in your chest Yes No
- Pain or tightness in your chest during physical activity Yes No
- Pain or tightness in your chest that interferes with your job Yes No
- In the past two years, have you noticed your heart skipping or missing a beat Yes No
- Heartburn or indigestion that is not related to eating Yes No
- 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?

- Breathing or lung problems Yes No
- Heart trouble Yes No
- Blood pressure Yes No
- Seizures (fits) Yes No



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8. Have you used a respirator? Yes No

If NO, go to question 9.

If YES, have you ever had any of the following problems?

Eye irritation Yes No

Skin allergies or rashes Yes No

Anxiety Yes No

General weakness or fatigue Yes No

Any other problems that interfere 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

11. Do you currently have any of the following vision problems?

Wear contact lenses Yes No

Wear glasses Yes No

Color blind Yes No

Any other eye or vision problem Yes No

12. Have you ever had an injury to your ears, including a broken ear drum Yes No

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

Difficulty hearing Yes No

Wear a hearing aid Yes No

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?

Weakness in any of your arms, hands, legs, or feet Yes No

Back pain Yes No

Difficulty fully moving your arms and legs Yes No

Pain or stiffness when you lean forward or backward at the waist Yes No

Difficulty fully moving your head up or down Yes No

Difficulty fully moving your head side to side Yes No

Difficulty bending at your knees Yes No

Difficulty squatting to the ground Yes No

Climbing a flight of stairs or a ladder carrying more than 25 lbs Yes No

Any other muscle or skeletal problem that interferes with using a respirator Yes No