Business Health Services
at Legacy Woodburn Health Center
1475 Mt. Hood Avenue
Woodburn, Oregon 97071
971.983.5340 legacyhealth.org/bhs

REPORT DATE:	USE EXPIRATION DATE:

RECORD AND REPORT OF MEDICAL EVALUATION

EMPLOYEE RESPIRATORY PROTECTION PROGRAM

Under federal Occupational Health regulations (OR-OSHA 1910.134 - available at www.OSHA.gov), an employee assigned to job duties that require the use of special respiratory Personal Protective Equipment is evaluated by a health care provider prior to being fit tested and beginning these job duties to determine that he/she is "medically able to use a respirator". This evaluation is based on considerations of the job duties and the types of respiratory equipment required as well as one or more of the following: a mandatory questionnaire, a medical and work history, spirometry (pulmonary function test), a medical examination or other tests and procedures.

THIS PAGE ONLY TO BE FILLED OUT BY EMPLOYER. PRINT CLEARLY IN INK, THIS BECOMES A PERMANENT RECORD.

EMPLOYEE NAME:	SEX ☐ M ☐ F	DOB	EMPLOYEE PHONE
JOB DUTIES:		COMPANY:	

Types and weights of respirators:		
Duration and frequency of use:		
Expected physical work effort:		
Additional protective clothing to be worn:		
Temperature and/or humidity extremes:		
Is respirator use mandatory or voluntary:	☐ mandatory	☐ voluntary

RESPIRATOR FIT TEST RESULT - DO NOT FILL OUT ITEMS BELOW

Based upon a review of the information developed through the evaluation process and taking into account the anticipated demands of the tasks and equipment involved in this job assignment it is my finding that:

☐ This individual has no apparent history or medical condition that would indicate that this individual is not in adequate health to be MEDICALLY ABLE to properly use the appropriate respiratory P.P.E.

☐ This individual has a history or medical condition that warrants special consideration or adaptation prior to assignment to this job and the required respiratory P.P.E. (SEE BELOW)

☐ This individual has a history or medical condition that warrants further investigation or evaluation before it can be determined that the individual is "medically able" to use the assigned respiratory protective equipment. (NOTED FOR EMPLOYEE IN SPACE BELOW.)

☐ It is medically inadvisable that this employee be assigned to these tasks at this time.

RECOMMENDATIONS AND LIMITATIONS (employee and/or workplace):

PROVIDER'S SIGNATURE	NAME AND DEGREE	DATE

INITIAL "RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE"

EMPLOYEE NAME (Last, First, MI):	TODAY'S DATE	SEX ☐ M ☐ F	AGE TO THE NEAREST YEAR	BIRTH YEAR

HOME ADDRESS: CITY: STATE: ZIP:	HEIGHT: ___ft ___in	WEIGHT: _____ lbs	PHONE NUMBER FOR EVALUATOR TO REACH YOU

EMPLOYER/COMPANY:	JOB REQUIRING RESPIRATOR	BEST TIME TO PHONE YOU

This Questionnaire, to be filled out by the employee, is part of the Company's written Respiratory Protection Program and is intended to ensure employees are medically able to wear a mask and that they wear it properly in order to protect their health. This information will be reviewed by a provider who will evaluate that medical ability. In some cases, there may be further testing as part of the evaluation process, such as a follow-up medical examination, a pulmonary function test, etc.

This evaluation will be done by the provider identified on page 6 of this form. The provider's name, address and telephone number are posted at the Company.

This evaluation is required before you can be assigned to jobs at the Company that require respiratory protection. Please answer each question honestly and to the best of your ability. To maintain your confidentiality, your employer must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the provider who will review it. The information you provide is confidential and is not released to the Company unless a Release of Information, provided by the Company, is signed by the employee and kept on file at the Company. These questions are required by occupational safety and health regulations. (please print your answers so they are readable).

PART A, SECTION 1 (MANDATORY)

A. Has your employer told you or have you been told how to contact the health care professional who will review this Questionnaire? *(circle)* Yes No

B. Check the types of respirators you will be using on this job:
- ☐ **N**ot resistant, **R**esistant or Oil **P**roof filter disposable mask;
- ☐ Half or full face **N**, **R** or **P** Cartridge filter reusable mask;
- ☐ Half or full face powered filter mask;
- ☐ Half or full face supplied airline mask;
- ☐ Half or full face self-contained Breathing Apparatus.
- ☐ Other:_____

C. Have you worn a respirator in the past? *(circle)* Yes No
If "yes"; what types (can answer in box on Page 4, item 17)? _____

D. Did you experience any difficulty breathing while using these respirators? *(circle)* Yes No
If "yes", describe the difficulty (can answer on Page 4): _____

PART A, SECTION 2 (MANDATORY) Questions 1 through 10 must be answered by every employee who has been selected to use any type of respirator (please circle):

1. Do you ***currently*** smoke tobacco or ***have you*** smoked tobacco in the last month? *(circle)* Yes No
2. Have you ***ever*** smoked/vaped other substances? *(circle)* Yes No
3. 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

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE -- page 3

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

a.	Asbestosis:	Yes	No	g.	Silicosis:	Yes	No
b.	Asthma:	Yes	No	h.	Pneumothorax (collapsed lung):	Yes	No
c.	Chronic Bronchitis:	Yes	No	i.	Lung cancer:	Yes	No
d.	Emphysema:	Yes	No	j.	Broken ribs:	Yes	No
e.	Pneumonia:	Yes	No	k.	Any chest injuries or surgeries	Yes	No
f.	Tuberculosis:	Yes	No	l.	Any other lung problem that you've been told about:	Yes	No

5. Do you ***now or in recent weeks have you had*** any of the following symptoms of pulmonary or lung illness?

a.	Shortness of breath	Yes	No	h.	Coughing that wakes you early in the morning:	Yes	No
b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	Yes	No	i.	Coughing that occurs mostly when you are lying down:	Yes	No
c.	Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes	No	j.	Coughing up blood in the last month:	Yes	No
d.	Have to stop for breath when walking at your own pace on level ground:	Yes	No	k.	Wheezing:	Yes	No
e.	Shortness of breath when washing or dressing yourself:	Yes	No	l.	Wheezing that interferes with your job:	Yes	No
f.	Shortness of breath that interferes with your job:	Yes	No	m.	Chest pain when you breathe deeply:	Yes	No
g.	Coughing that produces phlegm (thick sputum):	Yes	No	n.	Any other symptoms that you think may be related to lung problems:	Yes	No

6. Have you ***ever had*** any of the following cardiovascular or heart problems?

a.	Heart attack:	Yes	No	f.	Heart arrhythmia (heart beating irregularly):	Yes	No
b.	Stroke:	Yes	No	g.	High blood pressure:	Yes	No
c.	Angina:	Yes	No	h.	Any other heart problem that you've been told about:	Yes	No
d.	Heart failure:	Yes	No				
e.	Swelling in your legs or feet (not caused by walking):	Yes	No				

7. Have you ***ever had*** any of the following cardiovascular or heart symptoms?

a.	Frequent pain or tightness in your chest:	Yes	No	d.	In the past two years, have you noticed your heart skipping or missing a beat:	Yes	No
b.	Pain or tightness in your chest during physical activity:	Yes	No	e.	Heartburn or indigestion that is not related to eating:	Yes	No
c.	Pain or tightness in your chest that that interferes with your job:	Yes	No	f.	Any other symptoms that you think may be related to heart or circulation problem:	Yes	No

8. Do you ***now or in recent weeks have you taken*** **<u>medication</u>** for any of the following problems?

a.	Breathing or lung problems:	Yes	No	c.	Blood pressure:	Yes	No
b.	Heart trouble:	Yes	No	d.	Seizures:	Yes	No

9. 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 10): ☐

a.	Eye irritation:	Yes	No	d.	General weakness or fatigue:	Yes	No
b.	Skin allergies or rashes:	Yes	No	e.	Any other problem that interferes with your use of a respirator:	Yes	No
c.	Anxiety:	Yes	No				

10. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire (before the certificate is sent to the Company?) Yes No

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE -- page 4

Questions 11 to 16 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.

11. Have you ***ever lost*** vision in either eye (temporarily or permanently): Yes No

12. 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

13. Have you ***ever had*** an injury to your ears, including a broken or ruptured ear drum: Yes No

14. 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

15. Have you ***ever had*** a back injury: Yes No

16. 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 from side to side: Yes No
    g. Difficulty bending at your knees: Yes No
    h. Difficulty squatting to the ground: Yes No
    i. Difficulty 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

17. In the spaces below briefly explain ***every*** yes answer to questions 1-15:

No.	Letter	Explanation / Description:

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE -- page 5

PART B, SECTION 1 - WORK AND HOBBY HISTORY

1. Have you ever worked at a job or jobs that required you to wear a dust mask, filter mask, gas mask or S.C.B.A.? Yes No
   If so, what Jobs and for how long? _____

2. Have you ever worked at a job or jobs (including military service) where you were regularly exposed to dangerous dusts, airborne chemicals, mists, or gases? Yes No
   If so, what kinds of jobs, what exposures, how many days exposure in a year and how many years?

3. Do you have a secondary job or hobby where you are exposed to dusts, airborne chemicals, mists or gases? Yes No
   (for instance: farming, welding, painting, autobody work, etc.)
   If yes, what are those jobs or hobbies? What hazards? How many hours in any one year?

PART B, SECTION 2 - PHYSICAL CONDITION

1. Are you currently under a physician's supervision for a heart, lung or circulatory problem? Yes No
   Describe: _____

2. Do you experience prolonged shortness of breath during heavy exertion, long hill climbs, stair climbs, etc? Yes No
   Describe: _____

3. Have you ever had any major surgery for heart or lung problems? Yes No
   Describe: _____

4. Have you ever had any genetic, health, medical or surgical condition that caused difficulty breathing that would now interfere with drawing breath through a filter or gas mask? Yes No
   Describe: _____

5. Have you ever had any genetic, health, medical or surgical condition that caused facial tissue or bone irregularities that would interfere with a tight seal of the face piece of a filter or mask? Yes No
   Describe: _____

6. Do you have a perforated ear drum(s)? Yes No

7. Do you regularly wear prescription lenses while working? Yes - eyeglasses or contacts No

8. Have you ever been assigned to light duty work or been taken out of work assignment or been treated at a clinic or hospital for a job-related breathing or lung problem? Yes No
   If yes, when, why and how long? _____

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE -- page 6

PART B, SECTION 3 - JOB REQUIREMENTS

1. How long will you be expected to use the respirator? (circle yes or no for ***all*** answers that apply to you)
   a. Short term escape and rescue: Yes No
   b. A regular part of occasional work assignment: Yes No
   c. At all times for regular assignments of 2 or more hours some days: Yes No
   d. At all times for regular assignments 2 or more hours every day: Yes No

2. During the time you will be wearing the respirator, is your work effort:
   a. LIGHT (less than 200 kCal/hr. - examples: talking, sitting, sorting, or light assembly): Yes No
   b. MODERATE (to 350 kCal/hr. - examples: sitting while nailing or filing, transferring 35 lb. loads, walking, spraying, or pushing a cart): Yes No
   c. HEAVY (over 350 kCal/hr. - examples: lifting heavy loads, loading dock, bricklaying, construction, chipping castings, climbing stairs or ladders): Yes No

3. Will you be working in extremes of heat or cold? Yes No
   Describe: _____

4. Will you be wearing any "job specific" protective clothing? Yes No
   Describe: _____

5. Will you be encountering any particular hazardous conditions while wearing the respirator and working? Yes No
   (for example confined spaces, hazardous atmosphere, darkness, etc.)
   Describe: _____

PART B, SECTION 4 - MISCELLANEOUS

1. Do you have any physical or health conditions not mentioned above that may interfere with your ability to wear and carry respiratory protective equipment, to properly operate respiratory protective equipment (including drawing breath through filters) or to perform all of the movements and exertions of the required job while wearing and using the assigned respiratory protection equipment? Yes No
   Describe: _____

2. Do you have any particular medical, health, or safety concerns or questions that you would like answered before being assigned to jobs that require respiratory protection? Yes No
   What questions or concerns? _____

PROVIDER'S COMMENT / SIGNATURE

/S/ DATE _____

USE EXPIRATION DATE:

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