



OSHA RESPIRATOR MEDICAL CLEARANCE FORM

Appendix C to 1910.134: OSHA Respiratory Medical Evaluation Questionnaire (Revised April 2010 MHS)

Please complete the following fields:

1. Name: \_\_\_\_\_
2. Department Assigned: \_\_\_\_\_
3. Job Title: \_\_\_\_\_
4. Respirator(s) to be worn:
  - Half face mask (Microfiber filter mask, covers nose and mouth, no cartridge, i.e. N-95, particulate dust mask)
  - Half face mask (covers nose and mouth, made of rubber, with cartridge)
  - Full face mask (covers full face, made of rubber, with cartridge)
  - Powered Air Purifying (hood or full face mask with filtered air supply)
  - SCBA (self-contained breathing apparatus, i.e. Scott Pack)

Should the reviewing physician require additional information or it becomes necessary to perform a medical evaluation for your fit test suitability, you will be contacted directly by Meridian.

You may schedule your medical examination with Meridian Health Care during your normal work day through your supervisor based on operational need or from your personal time bank (sick, vacation, personal leave) according to your own schedule.

There is absolutely no need to disclose any personal protected medical information to your supervisor upon notification and necessary scheduling.

This section for Occupational Health Official Use ONLY:

LHCP Decision:

1.  Medically qualified for respirator use without restriction.
2.  Medically qualified for respirator use with the following restrictions: \_\_\_\_\_
3.  Defer decision, additional information required.
  - a.  Telephone call for clarification
  - b.  Needs medical evaluation, office visit to be scheduled
4.  Not medically qualified to use respirator.

This form was reviewed and based upon the accuracy of the information provided, as of this date, respirator use is approved for the type of respirator checked above ..

Comment: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Approval Date: \_\_\_\_\_



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Can you read English? (check one): Yes No

Your manager/supervisor must allow you to answer this questionnaire during normal working hours, or at a time and place this is convenient for you. To maintain confidentiality, your manager/supervisor must not look at or review your answers, and she or he must tell you how to send this to the health care professional who will review it.

Please check the type of respirator you will be required to wear: If you don't know which respirator you will be required to wear please consult your employer. You may check more than one.

- Half face mask (Microfiber filter mask, covers nose and mouth, no cartridge, i.e. N-95, particulate dust mask)
Half face mask (covers nose and mouth, made of rubber, with cartridge)
Full face mask (covers full face, made of rubber, with cartridge)
Powered Air Purifying (hood or full face mask with filtered air supply)
SCBA (self-contained breathing apparatus, i.e. Scott Pack)

Part A. Section I (Mandatory): Every employee who has been selected to use any type of respirator must, according to OSHA regulations, provide the following information. This information is not required for employees who voluntarily use dust masks for protection against nuisance dust.

PLEASE PRINT:

- 5. Date:
6. Name:
7. Address:
8. Date of Birth:
9. Sex: Male Female
10. Height: feet inches
11. Weight:
12. Job title:
13. Phone number where you can be reached by the health care professional who reviews this questionnaire (include area code):
14. The best time to phone you at this number:
15. Has your supervisor/manager told you how to contact the health care professional who will review this questionnaire? Yes No
16. Have you worn a respirator before? Yes No For how many years?
If 'Yes' what type? (see above list):
For what purpose (check one): Escape Rescue



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**Part A. Section 2. (Mandatory)** Every employee who has been selected to use any type of respirator must answer questions 1 through 9. **All "Yes" responses require detailed explanation in area provided on page 8**

		<u>Check YES or NO</u>
<b>1.</b>	<b>Do you currently smoke tobacco or have you smoked tobacco in the last month?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	How many packs? _____ How many years? _____	
<b>2.</b>	<b>Have you ever had any of the following conditions?</b>	
	(a) Seizures (fits)	Yes No
	(b) Diabetes (sugar disease)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(c) Allergic reaction that interfere with your breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(d) Claustrophobia (fear of closed-in places)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(e) Trouble smelling odors	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3.</b>	<b>Have you ever had any of the following pulmonary or lung problems?</b>	
	(a) Asbestosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(b) Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(c) Chronic Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(d) Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(e) Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(f) Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(g) Silicosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(h) Pneumothrorax (collapsed lung)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(i) Lung Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(j) Broken ribs	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(k) Any chest injuries or surgeries	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(l) Any lung problem that you have been told about	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4.</b>	<b>Do you currently have any of the following symptoms of pulmonary or lung illness?</b>	
	(a) Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(f) Shortness of breath that interferes with your job	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(g) Coughing that produces phlegm (thick sputum)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(h) Coughing that wakes you early in the morning	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(i) Coughing that occurs mostly when you are lying down	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(j) Coughing up blood in the last month	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(k) Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(l) Wheezing that interferes with your job	<input type="checkbox"/> Yes <input type="checkbox"/> No



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		<b>Check YES or NO</b>
	(m) Chest pain when you breathe deeply	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(n) Any other symptoms that you think may be related to lung problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>5.</b>	<b>Have you ever had any of the following cardiovascular or heart problems?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(a) Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(b) Stroke	Yes No
	(c) Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(d) Heart failure	Yes No
	(e) Swelling in your legs or feet not caused by walking	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(f) Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(g) High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(h) Any other heart problem that you have been told about	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>6.</b>	<b>Have you ever had any of the following cardiovascular or heart symptoms?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(a) Frequent pain or tightness in your chest	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(b) Pain or tightness in your chest during physical activity	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(c) Pain or tightness in your chest that interferes with your job	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(d) In the past two years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(e) Heartburn or indigestion that is not related to eating	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(f) Any other symptoms that you think may be related to heart or circulation problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(g) Do you currently take any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>7.</b>	<b>Do you take medication for any of the following problems?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(a) Breathing or lung problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(b) Heart trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(c) Blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(d) Seizures (fits)	Yes No
	(e) Seasonal allergies, hay fever, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>8.</b>	<b>If you've used a respirator, have you ever had any of the following problems?</b>	
	(a) Eye irritation	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(b) Skin allergies or rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(c) Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(d) General weakness or fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(e) Any other problems that interferes with the use of your respirator	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>9.</b>	<b>Would you like to talk to the health care professional who will review this questionnaire about your answers to this question?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No



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**QUESTIONS 10-15**

**THESE QUESTIONS MUST BE ANSWERED BY EVERY EMPLOYEE WHO IS REQUIRED TO USE EITHER A FULL-FACE 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.

	<u>Check YES or NO</u>
<b>10. Have you ever lost vision in either eye (temporarily or permanently)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>11. Do you currently have any of the following vision problems?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Wear contact lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Wear glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Color blind	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Any other eye or vision problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>12. Have you ever had an injury to your ears including a broken eardrum?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>13. Do you currently have any of the following hearing problems?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Difficulty hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Wear a hearing aid	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Any other hearing or ear problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>14. Have you ever had a back injury?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>15. Do you currently have any of the following musculoskeletal problems?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Weakness in any of your arms, hands, legs, or feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Difficult moving your arms and legs	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Pain or stiffness when you lean forward or backward at the waist	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) Difficulty moving your head up or down	<input type="checkbox"/> Yes <input type="checkbox"/> No
(f) Difficulty moving your head side to side	<input type="checkbox"/> Yes <input type="checkbox"/> No
(g) Difficulty bending at your knees	<input type="checkbox"/> Yes <input type="checkbox"/> No
(h) Difficulty squatting to the ground	<input type="checkbox"/> Yes <input type="checkbox"/> No
(i) Climbing a flight of stairs or a ladder, carrying more than 25 pounds	<input type="checkbox"/> Yes <input type="checkbox"/> No
(j) Any other muscle or skeletal problem that interferes with using a respirator	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>16. Have you fainted or passed out, or had periods of unconsciousness in the past year?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No



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**Part B.**

**If you are required to wear your respirator in a confined space, at low oxygen levels, in heated environments or during activities involving exposure to hazardous materials or chemicals, or in situations dealing with conditions that impose an immediate danger to life or health, please answer the following questions.** 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 feet) or in a place that has a lower than normal amount 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: \_\_\_\_\_

3. Have you ever worked with any of the materials, or under any of the conditions, listed below: Yes No

(a) Asbestos	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Silica (e.g., in sandblasting):	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Tungsten/Cobalt (e.g., grinding or welding this material)	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Beryllium	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) Aluminum	<input type="checkbox"/> Yes <input type="checkbox"/> No
(f) Coal (for example, mining)	<input type="checkbox"/> Yes <input type="checkbox"/> No
(g) Iron	<input type="checkbox"/> Yes <input type="checkbox"/> No
(h) Tin	<input type="checkbox"/> Yes <input type="checkbox"/> No
(i) Dusty environments:	<input type="checkbox"/> Yes <input type="checkbox"/> No
(j) Any other hazardous exposures:	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "Yes" describe these exposures: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

5. List your previous occupations: \_\_\_\_\_

6. List your current and previous hobbies: \_\_\_\_\_

7. Have you been in the military services? Yes No

If "yes", were you exposed to biological or chemical agents? (Either in training or combat): Yes No

8. Have you ever worked on a HAZMAT team? Yes No

9. Other than medications for breathing and lung problems, heart troubles, 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



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10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Canisters (for example, gas masks):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Cartridges:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

11. How often are you expected to use the respirator(s)?

a. Escape only (no rescue)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Emergency rescue only:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Less than 5 hours per week	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Less than 2 hours per day	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. 2 to 4 hours per day	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. Over 4 hours per day	<input type="checkbox"/> Yes	<input type="checkbox"/> 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: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

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: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

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: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

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 shipping 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 when you're wearing your respirator: Yes No

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): \_\_\_\_\_

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life threatening gases): \_\_\_\_\_



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18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when using your respirator(s):

Name of the first toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

Name of the second toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

Name of the third toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

The name of any other toxic substances that you'll be exposed to while using your respirator: \_\_\_\_\_

\_\_\_\_\_

19. Describe any special responsibilities you have while using your respirator (s) that may affect the safety and well-being of others (for example, rescue, security): \_\_\_\_\_

\_\_\_\_\_

**PLEASE EXPLAIN ALL "YES" RESPONSES**

Number	Explanation

I, the undersigned, shall report to management any changes in my health condition that are related to my ability to use a respirator and certify that the answers to the above questions are true to the best of my knowledge.

Employee's Signature (employee ID#): \_\_\_\_\_

Date: \_\_\_\_\_

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**Evaluation: Respirator Clearance**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

SS#: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Height	Males		Females		TEMPORARY DISQUALIFICATION CRITERIA	
(inches)	Optimal Weight (lbs)	35%	Optimal Weight (lbs)	35%	Identified problem areas require physician review and may necessitate further medical testing	
60	-	-	131	177	Vision	Unable to be corrected to 20/40
61	-	-	134	180	Hearing	Impairment requires further evaluation
62	150	202	137	185	Blood Pressure	>160 S or >90 D
63	153	206	140	189	Weight	>/equal to 35% over ideal
64	156	210	143	193	Pulmonary function	FVC or FEV 1 <60%
65	160	216	147	199	History of findings suggestive of	Any history or finding that prompts
66	164	221	151	204	Coronary artery disease without	The examiner to be concerned about
67	168	227	155	209	current "negative" stress test and/or	sudden incapacity or the ability to
68	172	232	159	215	Cardiology exam.	work safely, such as multiple risk
69	176	237	163	220	(Stress test must demonstrate > or	factors or a single extreme risk factor
70	180	243	167	226	equal 10 METs functional capacity	for coronary artery disease or a
71	184	248	170	229	with absence of arrhythmia, abnormal	significant musculoskeletal,
72	188	254	173	233	blood pressure response or ischemia)	neurological, psychological, endocrine
73	192	259	176	238		or dermatological disorder.
74	197	266	179	242		
75	202	272	-	-		
76	207	280	-	-		

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Snellen: \_\_\_\_\_

**Performed at PLHCP Request:**

Pulmonary Function (accept)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual Acuity (accept)	<input type="checkbox"/> Yes <input type="checkbox"/> No
EKG (normal)	<input type="checkbox"/> Yes <input type="checkbox"/> No
T.C. / HDL/Glucose (normal)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Audiogram (normal)	<input type="checkbox"/> Yes <input type="checkbox"/> No
HEENT (normal)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Facial configuration (normal)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart sounds (normal)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung sounds (normal)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Musculoskeletal (normal)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurologic (normal)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dermatologic (normal)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Approved for physical work:  Yes  No

Approved for respirator use and work in heat, stress and confined space environments:  Yes  No

If No, Restrictions: \_\_\_\_\_

Evaluating PLHCP's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Evaluating PLHCP's signature: \_\_\_\_\_