SMH Employee Health (EH)

Medical Clearance/Certification for Respirator Use

Employee Name_____ **Job Title** _____

********* DO NOT WRITE BELOW THIS LINE – FOR OEM OFFICE USE ONLY *******

Physician Certification

☐ 1 - Medically certified to use a N95/PAPR respirator
☐ 2 - Medically certified to use the following respirator(s) with restrictions or accommodations:
  ☐ N95
  ☐ PAPR
☐ 3 - Not medically certified for respirator use under any circumstances
  ☐ 3a-Temporary condition_____ ☐ 3b – Permanent Condition _____
☐ 4 – Employee needs to contact Employee Health regarding question #9.

Restrictions/Accommodations

☐ 1 - No restrictions/accommodations needed
☐ 2 - Corrective lens required
☐ 3 - No mask/PAPR use during exacerbation of pre-existing condition
☐ 4 - Not medically cleared pending respirator exam
☐ 5 - Call 487-1000 to schedule mask fit
☐ 6 - Call 487-1000 to schedule PAPR training
☐ 7 - Other _____

Recommendations

☐ 1 - Annual examination recommended
☐ 2 - Annual PFT to assess for adequate reserve for respirator use
☐ 3 - Follow up with personal physician
☐ Other _____

I certify that the above named employee has been evaluated to wear a respirator in accordance with OSHA Respiratory Protection Standard (29 CFR 1910.134), and that my findings are summarized above.

_____ _____

Provider Signature **Date**

University of Rochester
Employee Respirator Fit Test Record

Employee Name (print): _____ Date of Birth: _____ Job Title: _____

Company (if non-UR employee): _____

Respirator: ☐ Dust/Mist ☐ ½ Face APR ☐ Full Face APR ☐ PAPR ☐ Air Supplied ☐ SCBA

Manufacturer:	Manufacturer:	Manufacturer:
Model No. &/or Name:	Model No. &/or Name:	Model No. &/or Name:
Size:	Size:	Size:

Positive Pressure Check: ☐ Pass ☐ Fail Negati ve Pressure Check: ☐ Pass ☐ Fail

Qualitative: ☐ Pass ☐ Fail Test Agent: ☐ Saccharin ☐ Bittrex ☐ Isoamyl Acetate_____ Sensitivity Level

Qualitative Fit Test Elements (1 minute each):

1. Normal Breathing	☐ Pass	☐ Fail	5. Speaking	☐ Pass	☐ Fail
2. Deep Breathing	☐ Pass	☐ Fail	6. Forward Bend	☐ Pass	☐ Fail
3. Side to Side	☐ Pass	☐ Fail	7. Normal Breathing	☐ Pass	☐ Fail
4. Up and Down	☐ Pass	☐ Fail			

Quantitative: Quantitative Fit Test: ☐ Pass ☐ Fail Overall Fit Factor: _____

(Attach quantitative test results to this form)

Limitations: ☐ Facial Hair ☐ Dentures ☐ Eyeglasses ☐ None

Comments: _____

I have been successfully medically evaluated, fit tested, and instructed on the proper uses and limitations of the respirator(s) indicated above. I understand how t o perform both positive and negative pressure checks and I have been instructed to, and will perform them each time I wear a respirator. I will also inspect the parts of my respirator before each use for wear, cracks, tears, and other damage and will report any damage to my supervisor.

I reviewed the respirator training and had the opportunity to ask questions regarding it. I have been given the guidance document for the respirator(s) indicated above, and understand I can still ask questions or seek additional information.

I have taken the Respirator Fit Test Quiz and reviewed my answers with my fit test provider.

I will follow all respirator use procedures as appropriate, and seek guidance from my supervisor on any usage I am unsure of.

Employee Signature _____ Date _____

The above-named employee has successfully passed fit testing and is cleared to wear the respirator indicated above.

Performed by (print name): _____ Fit Test Date _____

Fit Test Provider's Signature: _____

UNIVERSITY OF ROCHESTER RESPIRATOR FIT QUIZ

Employee Name (print): _____ Date of Birth: _____ Job Title: _____

Company (if non-UR employee): _____

Choose the correct answer for the following questions **Check One**

1. If you are told to wear a respirator in a designated area, you should wear it whenever you:
   A. enter the area
   B. will be in the area for 10 minutes or longer
   C. can see, smell, or taste the hazard
   D. begin to feel sick as you work in the area
   ☐A ☐C ☐B ☐D

2. If you have a full face beard, the face mask style respirator will not fit properly. ☐T ☐F

3. When caring for suspected TB patients, you are required to wear a PAPR if you have a beard. ☐T ☐F

4. You must wear a respirator when you are seeing a patient with suspected or known TB. ☐T ☐F

5. You should throw away your old N95 respirator and get a new one if:
   A. the respirator looks worn or damaged
   B. the respirator has gotten wet
   C. the respirator does not seem to fit like it used to
   D. all of the above are correct
   ☐A ☐C ☐B ☐D

6. You must be properly trained and fit tested before wearing a respirator. ☐T ☐F

7. It is up to you to make sure that your respirator is in good condition before you wear it. ☐T ☐F

8. Wearing a respirator means that you do not need to be careful about what you are exposed to. ☐T ☐F

9. A respirator can only protect you if it:
   A. is worn properly
   B. is in good condition
   C. fits you well
   D. all of the above are correct
   ☐A ☐C ☐B ☐D

10. An N95 respirator will protect you from:
    A. dust
    B. mist
    C. tuberculosis
    D. all of the above are correct
    ☐A ☐C ☐B ☐D

11. To check the fit of your respirator, you must perform both positive and negative pressure checks. ☐T ☐F

12. If your respirator becomes damaged or malfunctions you should:
    A. take off the respirator and inspect it
    B. leave the area if you feel ill
    C. immediately leave the contaminated area
    D. finish your work and then go get a new one
    ☐A ☐C ☐B ☐D

13. In an emergency or equipment malfunction, you should leave the contaminated area immediately. ☐T ☐F

SMH Employee Health (EH)

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

Name: _____
Employee ID: _____
Occupation/Department: _____

To the Employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical exam

To the Employee: Can you read: (check 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)
Every employee who has been selected to use any type of respirator must provide the following information. (Please Print)

1. Today's date: _____
2. Your age (to nearest year) _____
3. Sex (check one) Male ☐ Female ☐
4. Your height _____ft _____in
5. Your weight _____lbs
6. Your job title _____
7. Phone number where you can be reached by the health care professional who reviews this questionnaire (include area code) _____
8. The best time to reach you at this number _____
9. Has your employer told you how to contact the health care professional who will review this questionnaire: (check one) Yes ☐ No ☐

10. 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)

11. Have you worn a respirator (check one) Yes ☐ No ☐

If "yes", what type(s) _____
_____
_____

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 check "yes" or "no"), **PLEASE EXPLAIN ANY"YES" RESPONSES. If there are no changes in your medical history since your last evaluation, please indicate "NO CHANGE".**

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?
    a. Seizures (fits) Yes ☐ No ☐
    b. Diabetes (sugar disease) Yes ☐ No ☐
    c. Allergic reactions that interfere with 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 you've been told of Yes ☐ No ☐

4. ****Do you currently have any of the following symptoms of pulmonary or lung disease:**
    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. Heart failure Yes ☐ No ☐

e. Swelling in 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've been told 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 chest interfering with job **Yes** ☐ **No** ☐

c. Pain or tightness in chest during physical activity **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 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 ever had any of the following problems?
(If you've never used a respirator, check the following box 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 ☐

Employee Signature:_____ **Date:** _____