

Training Attestation

Healthcare Respiratory Protection

By signing on the line below, I attest that I have completely read, and I understand, all information included in this training module.

Signature _____ Date _____

Printed Name _____

OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

Appendix C to Sec. 1910.134:

Part A. Section 1. (Mandatory) Every employee who has been selected to use any type of respirator (please print) must provide the following information.

Today's date _____	Date of Birth: _____
Name _____	SSN: _____
Job Title _____	Sex: Male <input type="radio"/> Female <input type="radio"/>
Home Phone: _____	Height: _____ (ft) _____ (in) Weight _____ (lbs)
Work Phone: _____	

Can you read English? Yes NO

Has your employer told you how to contact the health care professional who will review this? Yes NO

Check the type of respirator you will use (you can check more than one category):

a <input type="checkbox"/> N, R, or P disposable respirator (filter-mask, non-cartridge type only).	
b <input type="checkbox"/> Other type	<input type="checkbox"/> Powered-air purifier
<input type="checkbox"/> Half-face	<input type="checkbox"/> Supplied-air
<input type="checkbox"/> Full-facepiece type (includes gas mask)	<input type="checkbox"/> Self-contained breathing apparatus

Have you worn a respirator in the past?: Yes NO

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

Physical exertion while wearing a respirator Mild Moderate Strenuous

Maximum time you wear a respirator in a single day?: _____ hours

Do you exercise? Yes NO

If "yes," describe how often and what exercise activities are: _____

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 select "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes NO

If Yes, how many packs per day? 1/2 or less 1 2 2 or more

How many years have you smoked? 1-9 10-19 20-29 30 or more

2. Have you ever had any of the following conditions?

- Seizures (fits) Yes NO
- Diabetes (sugar disease) Yes NO
- Allergic reactions that interfere with your breathing Yes NO
- Claustrophobia (fear of closed-in places) Yes NO
- Trouble smelling odors 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
- 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/incline Yes NO
- Shortness of breath when walking with other people at an ordinary pace on level ground: Yes NO
- Have to stop for breath when walking at your own 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 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 symptoms 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

**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 space and go to question 9)**

- Eye irritation: Yes NO
- Skin allergies or rashes: Yes NO
- Anxiety: Yes NO
- General weakness or fatigue: Yes NO
- 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

SUPPLEMENTAL: If you are required to use a full-face peice respirator or a Self-Contained Breathing Aparatus (SCBA), complete the following: (If you do not, please sign below.)

- 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 glasses: Yes NO
- Wear contact lenses: 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

Any additional comments you would like to make:

To the best of my knowledge, the information I have provided is true and accurate.

Employee Signature _____ **Date** _____

TO BE COMPLETED BY THE EXAMINER/REVIEWER:

This employee has been found to be physically able to use the following (check each [] that applies):

- | | |
|--|--|
| <input type="checkbox"/> Single use, filter mask (four attachment points) | <input type="checkbox"/> Full-faced powered cartridge-type (PAPR) |
| <input type="checkbox"/> Half-faced cartridge-type, negative pressure | <input type="checkbox"/> Self-contained breathing apparatus (SCBA) |
| <input type="checkbox"/> Full-faced cartridge-type respirator, negative pressure | <input type="checkbox"/> Hood/helmet powered cartridge-type (PAPR) |
| <input type="checkbox"/> Half-faced powered cartridge-type (PAPR) | <input type="checkbox"/> Half-faced/Full-faced/Hood/Helmet (NOT positive pressure) |

Restrictions / Limitations (if any) when wearing a respirator:

- This employee has been found to be physically NOT able to use a respirator***
- There is insufficient information to make a determination at this time***
- The mandatory questionnaire has been reviewed, and the employee has been found to be physically able to use a respirator.***
- The mandatory questionnaire has been reviewed but there is insufficient information to make a determination at this time.***

This respirator clearance expires 1 2 3 years from the date below. (If not marked, clearance expires in 1 year)

Reviewer's Name (Print) _____ **Reviewer's Signature** _____ **Date:** _____