RPP Appendix C: Medical Clearance Questionnaires

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

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

To the employee:

Your employer must allow you to answer the 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 healthcare 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).

Name (Print Clearly): _____ Today's Date: _____

Date of Birth:_____ Age:_____ Sex:_____

Height:_____ Weight:_____ Job Title:_____

A **phone number** where you can be reached by the healthcare professional who reviews this questionnaire (include the Area Code): (_____) _____-_____ The best time to call you at this number: _____

Has your employer told you how to contact the healthcare professional who will review this questionnaire? ☐ 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 type (for example, half- or full-facepiece type,(powered-air purifying,) supplied-air, self-contained breathing apparatus).

Have you worn a respirator: ☐ 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 select "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:	Yes ☐	No ☐	Claustrophobia (fear of closed-in spaces):	Yes ☐	No ☐
Diabetes(sugar disease):	Yes ☐	No ☐	Allergic reactions that interfere with breathing:	Yes ☐	No ☐
Trouble smelling odors:	Yes ☐	No ☐			

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

Asbestosis:	Yes ☐	No ☐	Silicosis:	Yes ☐	No ☐
Asthma:	Yes ☐	No ☐	Pneumothorax (collapsed lung)	Yes ☐	No ☐
Chronic bronchitis:	Yes ☐	No ☐	Lung cancer:	Yes ☐	No ☐
Emphysema:	Yes ☐	No ☐	Broken ribs:	Yes ☐	No ☐
Pneumonia:	Yes ☐	No ☐	Any chest injuries or surgeries:	Yes ☐	No ☐
Tuberculosis:	Yes ☐	No ☐	Any other lung problem that you've been told about:	Yes ☐	No ☐

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

Shortness of breath:	Yes ☐	No ☐	Wheezing:	Yes ☐	No ☐
Chest pain when you breathe deeply:	Yes ☐	No ☐	Wheezing that interferes with your job:	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 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 ☐
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 ☐	Heart arrhythmia (heart beating irregularly):	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	High blood pressure:	Yes ☐	No ☐
Angina	Yes ☐	No ☐	Any other heart problem that you've been told about:	Yes ☐	No ☐
Heart Failure	Yes ☐	No ☐	Swelling in your legs or feet (not caused by walking):	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 you 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 ☐
Seizures:	Yes ☐	No ☐	Blood pressure:	Yes ☐	No ☐

8. If you've used a respirator, have you ever had any of the following problems? (if you have never used a respirator, check the following box and go to question 9): I've never used a respirator ☐

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 ☐

If you answered YES to any of these questions, please describe below:

_____

_____

_____

_____

9. Would you be able to wear a respirator without any difficulty? Yes ☐ No ☐

10. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Yes ☐ No ☐

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You will be required to have both annual fit testing and refresher training. Your anticipated level of work effort is moderate and expected frequency of use falls into the occasional use category.

I verify that the above information is true and complete to the best of my knowledge. I hereby give permission for a physical examination *if needed) to determine my suitability for respirator use. I understand that this examination is designed to satisfy regulatory requirements and should not be considered to be a routine medical evaluation. I agree to "self-report" changes in my medical condition that may affect my ability to safely wear a respiratory by contacting my respiratory program administrator.

Employee Signature: _____ Date:_____

11. Does the employee require further medical evaluation prior to fit testing? Yes ☐ No ☐

Reviewed By: _____ Date: _____

Signature: _____ Date: _____