OSHA Respirator Medical Evaluation Questionnaire
MANDATORY

To the employee: **Can you read?** *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. The following information must be provided by every employee who has been selected to use any type of respirator *(please print).*

Today's Date_____

Your Name:_ _____ Your age:_____ _____
(to nearest year)

Sex (circle one): *Male Female* Your height:__ __ft. _____n. Your weight: _____lb.

Your job title:__ _____

Phone number where you can be reached by the health care professional who reviews this questionnaire (include area code): _____

The best time to phone you at this number: _____ _____

Has your employer told you how to contact the health care professional who will review this questionnaire *(circle one):* *Yes* *No*

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

___ N, R, or P disposable respirator (filter-mask, non-cartridge type only)

_X_ Other type (for example, half-or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

2. Have you worn a respirator (circle one): *Yes No* If "yes," what type(s)?:

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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 circle "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?
   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*

3. Have you *ever had* any of the following pulmonary of 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 problem that you've been told about: *Yes* *No*

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?
   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 your 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 about: *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 your chest during physical activity: *Yes* *No*
   c. Pain or tightness in your chest that interferes with your job: *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 space 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*

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SCBA Questions

Questions 10 to 15 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.

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?
    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

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?
    a. Difficulty hearing: Yes No
    b. Wear a hearing aid: Yes No
    c. 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?
    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 side to side: Yes No
    g. Difficulty bending at your knees: Yes No
    h. Difficulty squatting to the ground: Yes No
    i. Climbing a flight of stairs or a ladder carrying more than 25 lb.: Yes No
    j. Any other muscle or skeletal problem that interferes with using a respirator: Yes No

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Part B. Any of the following questions, and 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 5000 feet) or in a place that has lower than normal amounts 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:
   a. Asbestos: Yes No
   b. Silica (e.g., in sandblasting): Yes No
   c. Tungsten/cobalt (e.g., grinding or welding this material): Yes No
   d. Beryllium: Yes No
   e. Aluminum: Yes No
   f. Coal (for example, mining): Yes No
   g. Iron: Yes No
   h. Tin: Yes No
   i. Dusty environments: Yes No
   j. Any other hazardous exposures: Yes 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

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

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

10. Will you be using any of the following items with your respirator(s)?
    a. HEPA Filters: Yes No
    b. Canisters (for example, gas masks): Yes No
    c. Cartridges: Yes No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you):
    a. Escape only (no rescue): Yes No
    b. Emergency rescue only: Yes No
    c. Less than 5 hours *per week*: Yes No
    d. Less than 2 hours *per day*: Yes No
    e. 2 to 4 hours *per day*: Yes No
    f. Over 4 hours *per day*: Yes 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: ____hr. _____min

    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 lb..) or controlling machines.

    b. *Moderate* (200-300 kcal per hour): Yes No
    If "yes", how long does this period last during the average shift: ____hr. _____min

    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 lb..) 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 lb..) 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: ____hr. _45__min

    Examples of heavy work are *lifting* a heavy load (about 50 lb..) from the floor to your waist or shoulder; *working* on a loading dock; shoveling; *standing* while bricklaying or chipping castings; *walking* up an 8-degree grade about 2 mph; *climbing* stairs with a heavy load (about 50 lb..).

13. Will you be wearing clothing and/or equipment (other than the respirator) when you're using your respirator: Yes No
If "yes", describe this protective clothing and/or equipment:

14. Will you be working under hot conditions (temperatures exceeding 77° 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):
IDLH Conditions, Confined Spaces, Radioactive Exposure, Trip/slip/fall hazardous due to limited visiability.

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're 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'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security): Rescue, Patching/Plugging leaks, and other forms of controlling a chemical leak.

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Employer Questionnaire

Employer Name:_____ County of York, Hazardous Materials Team_____

Address: _____120 Davies Dr. _____

City: _____York_____ State: _PA_ Zip Code: __17402_____

Contact Person: _____Thomas Graybill Jr., HazMat 91 Administrator_____

Phone Number: ____717-840-2913_____ FAX number: _____717-840-7406_

Date: _____

The following information must be provided to WORKFIRST before the health care provider makes a recommendation concerning an employee's ability to use a respirator:

A. The type and weight of the respirator to be used by the employee:

MSA, 60 minute, Self Contained Breathing Apparatus. Weight 40 Lbs

B. The duration and frequency of respirator use (including use for rescue and escape):

Bottles are 60 minutes. Our Procedure allows for 20 minutes to get in, 20 minutes to do necessary work and 20 minutes to get out and THROUGH decon. Time is controlled by "Entrance and Safety Officers".

C. The expected physical work effort:

Should be 20 minutes of heavy work, in SCBA and Level "A" totally encapsulated suit.

D. Additional protective clothing and equipment to be worn:

General entrance to hazmat area, Level "A" encapsulated suit.

E. Temperature and humidity extremes that may be encountered:

Workers could encounter average temperature and humidity of the area, and time of year. There are also facilities which have extremes in cold as in cold storage facilities and heat as in proximity of enclosed areas in summer.

Please attach a list of employees to whom the respirator information on this page pertains.

The employer shall also provide WORKFIRST with a copy of the written respiratory protection program.