Rutherford County Government

OSHA Respirator Medical Evaluation Questionnaire

To the employee:

Can you read (circle one): Yes or No

Your supervisor 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 supervisor must not look at or review your answers. It is also the responsibility of Rutherford County Government to tell you how to deliver or send this questionnaire to the health care 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		TODAY'S DATE
JOB TITLE		SEX ☐ MALE ☐ FEMALE
AGE	HEIGHT _____ ft _____ in	WEIGHT _____ lbs
NUMBER WHERE YOU CAN BE REACHED (INCLUDE AREA CODE) ( )		BEST TIME TO REACH YOU AT THIS NUMBER
HAVE YOU BEEN TOLD HOW TO CONTACT THE MEDICAL PROFESSIONAL WHO WILL REVIEW THIS QUESTIONNAIRE? ☐ YES ☐ NO		
HAVE YOU WORN A RESPIRATOR? ☐ YES ☐ NO		IF "YES," LIST THE TYPE(S) OF RESPIRATOR
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). _____ OTHER TYPE (FOR EXAMPLE, HALF- OR FULL-FACEPIECE TYPE, POWERED-AIR PURIFYING, SUPPLIED-AIR, SELF-CONTAINED BREATHING APPARATUS).		

Part A – Section 2 (Mandatory) The following questions must be answered by every employee who has been selected to use any type of respirator.

Do you **currently** smoke tobacco, or have you smoked tobacco in the last month?	YES	NO
Have you **ever had** any of the following conditions?		
Seizures (fits)	YES	NO
Trouble smelling odors	YES	NO
Diabetes (sugar disease)	YES	NO
Claustrophobia (fear of closed-in places)	YES	NO
Allergic reactions that interfere with your breathing	YES	NO
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 have been told about	YES	NO
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 waling 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
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 problems	YES	NO
Have you **ever had** any of the following cardiovascular 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 have been told about	YES	NO
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 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
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	YES	NO
If you have used a respirator, have you **ever had** any of the following problems? (If you have never used a respirator, skip this question and proceed to the next question.)		
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
Would you like to talk to the medical professional who will review this questionnaire about your answers to this questionnaire?	YES	NO

The following questions 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.

Have you **ever lost** vision in either eye (temporarily or permanently)	YES	NO
Do you **currently** have any of the following vision problems?		
Wear contact lenses	YES	NO
Wear glasses	YES	NO
Color blind	YES	NO
Any other eye or vision problem	YES	NO
Have you **ever had** an injury to your ears, including a broken ear drum?	YES	NO
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
Have you **ever had** a back injury?	YES	NO
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
Pain or stiffness when you lean forward of 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

Part B – The medical professional, who will review the questionnaire, has the right to request answers to any of the following questions and other questions not listed.

In your present job, are you working at high altitudes (over 5,000 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 are working under these conditions	YES	NO
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:		
Have you ever worked with any of the materials, or under any of the conditions, listed below:		
Asbestos	YES	NO
Silica	YES	NO
Tungsten/cobalt (e.g. grinding or welding this material)	YES	NO
Beryllium	YES	NO

Aluminum	YES	NO
Coal (for example, mining)	YES	NO
Iron	YES	NO
Tin	YES	NO
Dusty environments	YES	NO
Any other hazardous exposures	YES	NO
If yes, describe these exposures		
List any second jobs or side businesses you have		
List your previous occupations		
List your current and previous hobbies		
Have you been in the military services	YES	NO
If yes, were you exposed to biological or chemical agents (either in training or combat)		
Have you ever worked on a HAZMAT team?	YES	NO
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 other reason (including over-the-counter medications)	YES	NO
If yes, name the medication if you know them.		
Will you be using any of the following items with your respirator(s)?		
HEPA filters	YES	NO
Canisters (for example, gas masks)	YES	NO
Cartridges	YES	NO
How often are you expected to use the respirator(s) – check all that apply		
Escape only (no rescue)	YES	NO
Emergency rescue only	YES	NO
Less than 5-hours **per week**	YES	NO
Less than 2-hours **per day**	YES	NO
2 to 4 hours per day	YES	NO
Over 4-hours per day	YES	NO
During the period you are using the respirator(s), is your work effort		
Light (e.g. – **sitting** while writing, typing, drafting, or performing light assembly work; or **standing** while operating a drill press of 1-3 lbs or controlling machines)	YES	NO
If yes, how long does this period last during the average shift	HRS	MINS
Moderate (e.g. – **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 of about 35-lbs at trunk level; **walking** on a level surface about 2mph or down a 5-degree grade about 3 mph; or **pushing** a wheelbarrow with a heavy load of about 100-labs on a level surface)	YES	NO
If yes, how long does this period last during the average shift	HRS	MINS
Heavy (e.g. – lifting a heavy load of about 50-lbs 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 of about 50-lbs)	YES	NO
If yes, how long does this period last during the average shift	HRS	MINS
Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using the respirator	YES	NO
If yes, describe the protective clothing and/or equipment		
Will you be working under hot conditions (temperature exceeding 77degrees F)	YES	NO
Will you be working under humid conditions	YES	NO
Describe the work you will be doing while you are using the respirator		
Describe any special or hazardous conditions you might encounter when you are using the respirator(s) (e.g. – confined spaces)		
Provide the following information, **if you know it**, for each toxic substance that you will be exposed to when you are using the respirator		
Name of the first toxic substance		
Estimated maximum exposure level per shift	Duration of exposure per shift	

Name of second toxic substance	
Estimated maximum exposure level per shift	Duration of exposure per shift
Name of third toxic substance	
Estimated maximum exposure level per shift	Duration of exposure per shift
Describe any other special responsibilities you will have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security)	

I certify that the answers provided for the Respirator Medical Evaluation Questionnaire are herein true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to disciplinary action – up to and including termination.

Employee's Signature **Date**

Rutherford County Government

OSHA Respirator Medical Certification

NAME	TODAY'S DATE
SUPERVISOR	DEPARTMENT

☐ Is medically approved for respirator use without restrictions.

☐ Is not medically approved for respirator use.

☐ Is medically approved for respirator use with the following restrictions:

_____

_____

_____

Other comments:

_____

_____

_____

This certification is good for two years. However, it is the responsibility of the employee to notify their supervisor if potentially relevant health problems or accidents arise before then.

_____
Physician's Signature

_____
Physician (Print name)

_____
Medical Facility

Distribution : Employee
Supervisor (A copy goes in the employee's file.)