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RESPIRATOR CERTIFICATION QUESTIONNAIRE

Part A Section 1 (Mandatory completion by each employee required)

1. Today's Date ______ SS# or Employee ID# ______ Company/Location ______
2. Last Name ______ First Name ______
3. Age ______ 4. Sex M ☐ F ☐ 5. Height ______ 6. Weight ______
7. Job Title or Description ______
8. Phone number you can be reached at by the medical professional who reviews this questionnaire:
   Work ______ Home ______ 9. Best time to call AM ☐ PM ☐
10. *Has your employer told you how to contact the medical professional reviewing this questionnaire?* Yes ☐ No ☐
11. 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 (check all that apply): half mask ☐ full mask ☐ SCBA ☐ powered-air ☐ supplied-air ☐
12. Have you worn a respirator before? Yes ☐ No ☐ Types: ______
13. Facility ______ Date of Test ______
14. Expected usage and duration (check appropriate level):
    Escape only ☐ Emergency rescue only ☐ < 5hrs/wk ☐ < 2hrs/day ☐ < 2-4 hrs/day ☐ < 4hrs/day ☐
15. Level of physical exertion: Light ☐ Moderate ☐ Heavy ☐ Intermittent ☐ Sustained ☐
16. Environment: Hot ☐ Cold ☐ Altitude>5000 ft. ☐ Confined space ☐ Wearing heavy equipment ☐
17. Potential exposures: Dust ☐ Asbestos ☐ Cotton ☐ Silica ☐ Ammonium ☐ Tungsten ☐ Beryllium ☐
    Aluminum ☐ Coal ☐ Iron ☐ Organic chemicals ☐ Others ______

Results (Respirator certification requires proper training, fit testing, and absence of facial hair that interferes with seal.)

☐ Approved for NIOSH certified respirator usage without restriction

☐ Approved for NIOSH approved respirator usage with the following restrictions:

N, R, or P (dust mask) only ☐ Pos. Pressure ☐ SCBA ☐ Neg. Pressure ☐ Air Power ☐

☐ Other restrictions: ______

☐ Not qualified because ______

☐ Qualification requires additional information or testing ______

☐ The evaluation indicates that there may be a medical problem requiring consultation with the employee's physician ______

Next recommended respirator certification assessment? Date ______

Questionnaire only ☐ PFT ☐ Other ______

(I have reviewed the results of this employee's medical examination in compliance with OSHA 29 CFR 1910.134)

Physician Signature ______ Date ______

Thomas C. Jetzer MD MPH ☐ Richard Hirt MD ☐ Other ______

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 check “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?
   1. Seizures (fits)........ Yes ☐ No ☐
   2. Diabetes (sugar disease) .... Yes ☐ No ☐
   3. Allergic reactions that interfere with your breathing .... Yes ☐ No ☐
   4. Claustrophobia (fear of closed-in places) .... Yes ☐ No ☐
   5. Trouble smelling odors........ Yes ☐ No ☐

3. Have you ***ever had*** any of the following pulmonary or lung problems?
   1. Asbestosis .... Yes ☐ No ☐
   2. Asthma........ Yes ☐ No ☐
   3. Chronic bronchitis........ Yes ☐ No ☐
   4. Emphysema .... Yes ☐ No ☐
   5. Pneumonia........ Yes ☐ No ☐
   6. Tuberculosis .... Yes ☐ No ☐
   7. ilicosis .... Yes ☐ No ☐
   8. Pneumothorax (collapsed lung)........ Yes ☐ No ☐
   9. Lung cancer........ Yes ☐ No ☐
   10. Broken ribs........ Yes ☐ No ☐
   11. Any chest injuries or surgeries........ Yes ☐ No ☐
   12. 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?
   1. Shortness of breath .... Yes ☐ No ☐
   2. Shortness of breath when walking fast on level ground or walking up a slight hill or incline .... Yes ☐ No ☐
   3. Shortness of breath when walking with other people at an ordinary pace on level ground........ Yes ☐ No ☐
   4. Have to stop for breath when walking at your own pace on level ground .... Yes ☐ No ☐
   5. Shortness of breath when washing or dressing yourself........ Yes ☐ No ☐
   6. Shortness of breath that interferes with your job .... Yes ☐ No ☐
   7. Coughing that produces phlegm (thick sputum) .... Yes ☐ No ☐
   8. Coughing that wakes you early in the morning .... Yes ☐ No ☐
   9. Coughing that occurs mostly when you are lying down .... Yes ☐ No ☐
   10. Coughing up blood in the last month .... Yes ☐ No ☐
   11. Wheezing........ Yes ☐ No ☐
   12. Wheezing that interferes with your job........ Yes ☐ No ☐
   13. Chest pain when you breathe deeply .... Yes ☐ No ☐
   14. 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?
   1. Heart attack .... Yes ☐ No ☐
   2. Stroke........ Yes ☐ No ☐
   3. Angina........ Yes ☐ No ☐
   4. Heart failure........ Yes ☐ No ☐
   5. Swelling in your legs or feet (not caused by walking) .... Yes ☐ No ☐
   6. Heart arrhythmia (heart beating irregularly)........ Yes ☐ No ☐
   7. High blood pressure........ Yes ☐ No ☐
   8. 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?
   1. Frequent pain or tightness in your chest .... Yes ☐ No ☐
   2. Pain or tightness in your chest during physical activity .... Yes ☐ No ☐
   3. Pain or tightness in your chest that interferes with your job........ Yes ☐ No ☐
   4. In the past two years, have you noticed your heart skipping or missing a beat .... Yes ☐ No ☐
   5. Heartburn or indigestion that is not related to eating........ Yes ☐ No ☐
   6. 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?
   1. Breathing or lung problems .... Yes ☐ No ☐
   2. Heart trouble .... Yes ☐ No ☐
   3. Blood pressure .... Yes ☐ No ☐
   4. Seizures (fits) .... Yes ☐ No ☐

8. Have you ever used a respirator before? .... Yes ☐ No ☐
   If you've used a respirator, have you ***ever had*** any of the following problems:
   1. Eye irritation .... Yes ☐ No ☐
   2. Skin allergies or rashes .... Yes ☐ No ☐
   3. Anxiety .... Yes ☐ No ☐
   4. General weakness or fatigue .... Yes ☐ No ☐
   5. 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 ☐

Please comment on any "Yes" answers in questions 1-8 below:

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If you have been selected to use a full-facepiece respirator or a self-contained breathing apparatus (SCBA), it is necessary that you answer the following additional questions:

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?
    1. Wear contact lenses .... Yes ☐ No ☐
    2. Wear glasses .... Yes ☐ No ☐
    3. Color blind .... Yes ☐ No ☐
    4. 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?
    1. Difficulty hearing .... Yes ☐ No ☐
    2. Wear a hearing aid .... Yes ☐ No ☐
    3. 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?
    1. Weakness in any of your arms, hands, legs, or feet .... Yes ☐ No ☐
    2. Back pain .... Yes ☐ No ☐
    3. Difficulty fully moving your arms and legs .... Yes ☐ No ☐
    4. Pain or stiffness when you lean forward or backward at the waist .... Yes ☐ No ☐
    5. Difficulty fully moving your head up or down .... Yes ☐ No ☐
    6. Difficulty fully moving your head side to side .... Yes ☐ No ☐
    7. Difficulty bending at your knees .... Yes ☐ No ☐
    8. Difficulty squatting to the ground .... Yes ☐ No ☐
    9. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs .... Yes ☐ No ☐
    10. Any other muscle or skeletal problem that interferes with using a respirator .... Yes ☐ No ☐

Please comment on any "Yes" answers to questions 10-15:

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