EMPLOYER AUTHORIZATION & INFORMATION FOR RESPIRATORY EVALUATION

EMPLOYER TO COMPLETE THE FOLLOWING:

Employee Name: _____ DOB: _____

Employer: _____ Address: _____

Employee SSN: _____ _____

Check type of Respirator(s) to be used. (Check ALL that apply)

☐ Air-purifying (non-powered)	☐ Air-purifying (powered)	☐ Atmosphere supplying Respirator
☐ Combination air-line and SCBA	☐ Continuous-Flow Respirator	☐ Supplied-Air Respirator
☐ Open Circuit SCBA	☐ Closed Circuit SCBA	
☐ Dust Mask	☐ ½ Face with Canisters	☐ Full Face with Canisters
Make: _____	Model: _____	Cartridge: _____

Special Work Conditions (Check ALL that apply when wearing respirator)

☐ High Places	☐ Enclosed Places	☐ Protective Clothing	☐ Temperature Extremes
☐ Mostly Cold	☐ Mostly Hot	☐ Other: _____	

Extent of Usage (Check ALL that apply)

- ☐ On a daily basis _____ Total Hours
- ☐ Occasionally – but not more than twice a week _____ Total Hours
- ☐ Rarely – or for Emergency situations only _____ Total Hours

Expected Physical Effort Required (Check ALL that apply)

☐ Light	☐ Moderate	☐ Heavy

Exposure to Hazardous Materials (Check ALL that apply)

☐ Arsenic	☐ Benzene	☐ Coke Oven	☐ Cotton Seed/Dust
☐ Cadmium	☐ Formaldehyde	☐ Methylene Chloride	☐ Lead
☐ Textiles	☐ Chromium		Others: _____

Evaluation Authorized by: _____

WRITTEN STATEMENT FOR RESPIRATORS (EMPLOYER)

PHYSICIAN WILL COMPLETE THE FOLLOWING

This report may contain confidential medical information and is intended for the designated employer contact only. The Americans with Disabilities Act (ASDA) imposes very strict limitations on the use of information obtained during physical examination of qualified individuals with disabilities. All information must be collected and maintained on separate forms, in separate files, and must be treated as a confidential medical record, with the following exceptions:

- Supervisors and managers may be informed about necessary restrictions on the work or duties of an employee and necessary accommodations.
- First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment

Based upon my findings, I have determined that this individual (Check ALL that apply)

- ☐ Employee must schedule a medical examination with _____ prior to respirator approval and usage.
- ☐ Class I – no Restrictions on Respirator Use
- ☐ Class II – Some specific Restrictions ☐ To be used for Emergency Response or Escape Only ☐ Other
- ☐ Class III – Respirator Use is NOT PERMITTED
- ☐ Further Testing/Evaluation is required
- ☐ Fit Test Required
- ☐ Fit Test Performed Unsatisfactorily
- ☐ Special prescription eyewear needed to accommodate respirator
- ☐ Facial hair needs to be shaved to assure tight seal on certain face masks

(Check ALL that apply)

- ☐ The above individual HAS been examined for respirator fitness in accordance with Chapter 296-842 WAC under the Washington Industrial Safety and Health Act. This limited evaluation is specific to respirator use only. Employees should be instructed to report any difficulties in using respirators or change of any physical status to their supervisor or physician. This evaluation included the Respiratory Questionnaire outlined in Chapter 296-842 WAC.
- ☐ The above individual HAS NOT been examined by me for respirator fitness. The employee's medical evaluation consisted of a review of OSHA's Medical Evaluation Questionnaire. In accordance with Chapter 296-842 WAC, this limited evaluation is specific to respirator use only. Employees would be instructed to report any difficulties in using respirators or change of any physical status to their supervisor or physician. This evaluation included the respiratory questionnaire outlined in Chapter 296-842 WAC.
- ☐ In accordance with specific WISHA requirements, I have informed the above named individual of the results of this evaluation and of any medical conditions resulting from exposures that may require further explanation or treatment. Where applicable, the above named individual has been informed of the increased risk of lung cancer attributable to the combined effect of smoking and asbestos, lead and/or other chemical exposure(s).

_____	_____	_____	_____
Physician's Signature	Physician's Name (printed)	Date of Exam	Expires on

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).

1. Today's date:
2. Your name:
3. Your age (to nearest year):
4. Sex (circle one): Male/Female
5. Your height: ft. in.
6. Your weight: lbs.
7. Your job title:
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):
9. The best time to phone you at this number:
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): 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 (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): 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 circle "yes" or "no").

	YES	NO
1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month?	☐	☐
2. Have you *ever had* any of the following conditions?	☐	☐
a. Seizures	☐	☐
b. Diabetes (sugar disease)	☐	☐
c. Allergic reactions that interfere with your breathing	☐	☐
d. Claustrophobia (fear of closed-in places)	☐	☐
e. Trouble smelling odors	☐	☐
3. Have you *ever had* any of the following pulmonary or lung problems?	☐	☐
a. Asbestosis	☐	☐
b. Asthma	☐	☐

	YES	NO
c. Chronic bronchitis	☐	☐
d. Emphysema	☐	☐
e. Pneumonia	☐	☐
f. Tuberculosis	☐	☐
g. Silicosis	☐	☐
h. Pneumothorax (collapsed lung)	☐	☐
i. Lung cancer	☐	☐
j. Broken ribs	☐	☐
k. Any chest injuries or surgeries	☐	☐
l. Any other lung problem that you've been told about	☐	☐
4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?	☐	☐
a. Shortness of breath	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
d. Have to stop for breath when walking at your own pace on level ground	☐	☐
e. Shortness of breath when washing or dressing yourself	☐	☐
f. Shortness of breath that interferes with your job	☐	☐
g. Coughing that produces phlegm (thick sputum)	☐	☐
h. Coughing that wakes you early in the morning	☐	☐
i. Coughing that occurs mostly when you are lying down	☐	☐
j. Coughing up blood in the last month	☐	☐
k. Wheezing	☐	☐
l. Wheezing that interferes with your job	☐	☐
m. Chest pain when you breathe deeply	☐	☐
n. Any other symptoms that you think may be related to lung problems	☐	☐
5. Have you *ever had* any of the following cardiovascular or heart problems?		
a. Heart attack	☐	☐
b. Stroke	☐	☐
c. Angina	☐	☐
d. Heart failure	☐	☐

	YES	NO
e. Swelling in your legs or feet (not caused by walking)	☐	☐
f. Heart arrhythmia (heart beating irregularly)	☐	☐
g. High blood pressure	☐	☐
h. Any other heart problem that you've been told about	☐	☐
6. Have you *ever had* any of the following cardiovascular or heart symptoms?	☐	☐
a. Frequent pain or tightness in your chest	☐	☐
b. Pain or tightness in your chest during physical activity	☐	☐
c. Pain or tightness in your chest that interferes with your job	☐	☐
d. In the past two years, have you noticed your heart skipping or missing a beat	☐	☐
e. Heartburn or indigestion that is not related to eating	☐	☐
f. Any other symptoms that you think may be related to heart or circulation problems	☐	☐
7. Do you *currently* take medication for any of the following problems?	☐	☐
a. Breathing or lung problems	☐	☐
b. Heart trouble	☐	☐
c. Blood pressure	☐	☐
d. Seizures	☐	☐
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	☐	☐
b. Skin allergies or rashes	☐	☐
c. Anxiety	☐	☐
d. General weakness or fatigue	☐	☐
e. Any other problem that interferes with your use of a respirator	☐	☐
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	☐	☐

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)?	☐	☐
11. Do you *currently* have any of the following vision problems?	☐	☐
a. Wear contact lenses	☐	☐
b. Wear glasses	☐	☐
c. Color blind	☐	☐
d. Any other eye or vision problem	☐	☐

	YES	NO
12. Have you *ever had* an injury to your ears, including a broken eardrum?	☐	☐
13. Do you *currently* have any of the following hearing problems?	☐	☐
a. Difficulty hearing	☐	☐
b. Wear a hearing aid	☐	☐
c. Any other hearing or ear problem	☐	☐
14. Have you *ever had* a back injury?	☐	☐
15. Do you *currently* have any of the following musculoskeletal problems?	☐	☐
a. Weakness in any of your arms, hands, legs, or feet	☐	☐
b. Back pain	☐	☐
c. Difficulty fully moving your arms and legs	☐	☐
d. Pain and stiffness when you lean forward or backward at the waist	☐	☐
e. Difficulty fully moving your head up or down	☐	☐
f. Difficulty fully moving your head side to side	☐	☐
g. Difficulty bending at your knees	☐	☐
h. Difficulty squatting to the ground	☐	☐
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.	☐	☐
j. Any other muscle or skeletal problem that interferes with using a respirator	☐	☐

This infosheet does not include the questions in Part B because they are not mandatory; rather, they may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

OSHA Educational Materials

OSHA has an extensive publications program. For a listing of free items, visit OSHA's web site at www.osha.gov/publications or contact the OSHA Publications Office, U.S. Department of Labor, 200 Constitution Avenue, N.W., N-3101, Washington, DC 20210. Telephone (202) 693-1888 or fax to (202) 693-2498.

Contacting OSHA

To report an emergency, file a complaint or seek OSHA advice, assistance or products, call (800) 321-OSHA (6742) or contact your nearest OSHA regional, area, or State Plan office; TTY: 1-877-889-5627.

This InfoSheet is not a standard or regulation, and it creates no new legal obligations. It contains recommendations as well as descriptions of mandatory safety and health standards. The recommendations are advisory in nature, informational in content, and are intended to assist employers in providing a safe and healthful workplace. The *Occupational Safety and Health Act* requires employers to comply with safety and health standards and regulations promulgated by OSHA or by a state with an OSHA-approved state plan. In addition, the Act's General Duty Clause, Section 5(a)(1), requires employers to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm.

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