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 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. (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 reviews 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").

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 or 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 problems that you have 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 cheat 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 2 years, have you noticed you heart skipping- or missed 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 lug 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 here _____ 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

Questions 10 to 15 below must be answered by every employee/volunteer who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees/volunteers 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 pounds Yes / No
    j. Any other muscle or skeletal problem that interferes with using a respirator Yes / No

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 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'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 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

If “yes,” were you exposed to biological or chemical agents (either in training or combat) 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

If “yes,” name the medications if you know them

_____

_____

Part B Section 2. The EMPLOYER must provide this supplemental information to the health care professional (PLHCP) who will review the employee's/volunteer medical questionnaire.

EMPLOYEE'S/VOLUNTEER NAME _____

1. What type of respirator will this employee use?
   Check the type(s) below (you can check more than one category)
   - _____ N-, R-, or P- filtering facepiece (disposable, "dusk mask" type)
   - _____ Tight-fitting, air-purifying half-mask,
   - _____ Tight-fitting full-face mask
     - _____ Air-purifying type
     - _____ Supplied air type
   - _____ Powered-air purifying respirator (PAPR)
     - _____ Tight-fitting, full face mask
     - _____ Loose-fitting helmet or hood
   - ✓ Self-Contained Breathing Apparatus (SCBA)
   - _____ Escape (gas mask)

2. What is the approximate weight of the respirator and any tanks or air hoses?
   29 lbs.

3. Will the employee use any of the following items with these respirator(s)?
   a. HEPA filters — Yes / No
   b. Canisters (gas Masks) — Yes / No
   c. Cartridges (air-purifying) — Yes / No

4. How often will the employee/volunteer use the respirator(s)? (circle "yes" or "no" for all answers that apply.
   a. Escape only (no rescue duties) — Yes / No
   b. Less than 2 hrs. per day — Yes / No
   c. Emergency rescue only — Yes / No
   d. 2 to 4 hrs. per day — Yes / No
   e. Less than 5 hrs. per week — Yes / No
   f. Over 4 hrs. per day — Yes / No

5. When the employee/volunteer uses the respirator(s), is their work effort

   a. Light (less than 200 kcal per hour) Yes / No

   If "yes," how long does this period last during the average shift

   Hrs._____ minis. _____

   Examples of light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while controlling machines.

   b. Moderate (200 to 350 kcal per hour) Yes / No

   If "yes," how long does this period last during the average shift

   Hrs._____ minis. _____

   Examples of moderate work effort are sitting while nailing or filing; driving a truck, drilling, nailing, performing assembly work, or transferring a moderate load (about 35 pounds) 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 pounds) on a level surface. (NOTE: a gallon of water weighs about 8 lbs; so, a full, 3-gallon, backpack sprayer weights about 25 lbs.)

   c. Heavy (above 350 kcal per hour) Yes / No

   If "yes," how long does this period last during the average shift?

   Hrs._____ minis. _____

   Examples of heavy work are lifting a heavy load (about 50 pounds) 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 pounds).

6. Will the employee wear protective clothing and/or equipment (other than the respirator) when using their respirator? Yes / No

   If "yes," describe this protective clothing and/or equipment – Helmet, hood, pants, coat, gloves, and boots.

7. Will they be working in hot conditions (temperature more than 77 degrees F)? Yes / No

8. Will they be working in humid conditions? Yes / No

9. Describe the work they will be doing while using their respirator(s)

   They will be pulling fire hose and spraying water, search-and-rescue, and using power tools to make entry into structures and vehicles

10. Describe any special or hazardous conditions they might encounter when using a respiratory protection (for example, confined spaces, oxygen-deficient atmospheres, life threatening gases)

    They will be working in oxygen-deficient atmospheres and life-threatening gases.

11. Provide the following information, if you know it, for each toxic substance that they will be exposed to when using their respirator(s).

    Name of the first toxic substance – Carbon Monoxide

    Estimated maximum exposure level per shift _____

    Duration of exposure per shift _____

    Name of the second toxic substance – Hydrogen Cyanide

    Estimated maximum exposure level per shift _____

    Duration of exposure per shift _____

    Name of the third toxic substance - Smoke

    Estimated maximum exposure level per shift _____

    Duration of exposure per shift _____

    Name of any other toxic substances that they will be exposed to while using a respirator

12. Describe any special responsibilities they will have while using their respirator(s) that may affect the safety and well-being of others (i.e., rescue, security)

    Search-and-Rescue of trapped people in structures and vehicles. Fire Suppression

Information to be Obtained from the Physician or Licensed Health Care Professional (PLHCP)

The employee _____ **is / is not** able to wear a Self-Contained Breathing Apparatus (SCBA).

Any limitation in the wearing of the SCBA: _____

_____

_____

_____

Any follow-up required: _____

_____

_____

_____

☐ The employee has been supplied with a copy of this evaluation.

Date: _____ Signature _____

Name of PLHCP: _____

Address:_____

Phone:_____

administered.