

## Employee respiratory protection medical evaluation instructions

### Complete the following steps:

1. Print, and complete
2. Send to ASU Employee Health
  - Email directly to [karen.stevenson@asu.edu](mailto:karen.stevenson@asu.edu) with the subject: “[SECURE] Respiratory Protection Questionnaire.”
  - Or, via interoffice mail in a sealed envelope marked: “[SECURE] Respiratory Protection Questionnaire” to:

Karen Stevenson, BSN, RN  
 ASU Employee Health  
 Mail Code 3011

3. Be sure to fill in the form completely including your department name, ASU ID# and other information necessary for billing purposes.
4. Upon Employee Health approval, you will be issued an OSHA Respirator Medical Evaluation Clearance Letter
5. Once Medical Clearance is provided, you may schedule your Respirator Fit Test through your Employee Health portal at: [asuportal.pointnclick.com/Mvc/Portal/Login](http://asuportal.pointnclick.com/Mvc/Portal/Login)
6. Men must be **clean-shaven** for their respirator fit test and whenever respirator is in use. For reference see for approved facial hair: [cdc.gov/niosh/npptl/pdfs/facialhairwmask11282017-508.pdf](http://cdc.gov/niosh/npptl/pdfs/facialhairwmask11282017-508.pdf)

### Available respirators:

N95 available respirators			Half-face respirators		
Manufacturer	Style	Size	Manufacturer	Style	Size(s)
3M	1860	Small	3M	6500 Series	S, M, L
3M	8210	Regular	MSA	200LS	S, M, L
3M	VFlex 9105	Regular	North	7700	S, M, L
3M	Aura 9210+	Small	<b>Full-face respirators</b>		
BYD	DE2322	One-Size	MSA	Millenium	S, M, L
Honeywell	DC300	One-Size	MSA	4000	S, M, L

## **Additional information**

The initial baseline medical evaluation requirements for respiratory protection consist of the following:

### **Medical history**

The employee must complete the “OSHA Respirator Medical Evaluation Questionnaire”. The history should focus on the respiratory and cardiovascular systems. It should also include questions about difficulties that may have been experienced with prior respirator use.

### **Medical examination**

The medical examiner must be by a professionally licensed health care provider, or PLHCP, and have knowledge of the respirator types, level of work effort, extent of use, and work history. The exam shall focus on the respiratory and cardiovascular systems. In addition, any “yes” responses on the “Medical History Questionnaire” should be detailed. Facial deformities, other physical characteristics or requirement to wear glasses should also be noted.

**Cited from: OSHA Regulations (Standards - 29 CFR) OSHA Respirator Medical Evaluation Questionnaire (Mandatory). - 1910.134**

**Appendix C**

- Standard Number: 1910.134 Appendix C.
- Standard Title: OSHA Respirator Medical Evaluation Questionnaire (Mandatory).
- SubPart Number: I
- SubPart Title: Personal Protective Equipment.

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.

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 one | 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 ASU ID#: \_\_\_\_\_
4. Your department name: \_\_\_\_\_
5. If research related, name of PI: \_\_\_\_\_
6. Your date of birth: \_\_\_\_\_
7. Sex – check one: Male \_\_\_\_\_ Female \_\_\_\_\_ Other \_\_\_\_\_
8. Your height: \_\_\_\_\_ ft. \_\_\_\_\_ in.
9. Your weight: \_\_\_\_\_ lbs.

10. Your job title: \_\_\_\_\_
11. A phone number where you can be reached by the professionally licensed health care provider, or PLHCP, who reviews this questionnaire (include the area code):  
\_\_\_\_\_
12. The best time to phone you at this number: \_\_\_\_\_
13. Has your employer told you how to contact the professional health care professional who will review this questionnaire? Check one: Yes \_\_\_\_\_ No \_\_\_\_\_
14. 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, including N95.
- \_\_\_\_\_ Other type – for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus.
15. Have you worn a respirator? Check one: Yes \_\_\_\_\_ No \_\_\_\_\_
- **If yes**, what type(s): \_\_\_\_\_

## Part A

### Section two | Mandatory

Questions one through nine 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?
  - 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 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 have used a respirator, have you **ever had** any of the following problems? **If you have never used a respirator, skip to the next question.**
- 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 who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus, or 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 eardrum? 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 side to side: Yes \_\_\_\_\_ No \_\_\_\_\_
- f. Difficulty fully moving your head up or down: 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 lbs: 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, **please complete this section.**

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 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:
- k. Yes \_\_\_ No \_\_\_

If yes, describe these exposures:

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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 in 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: \_\_\_\_\_

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) (check "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 five hours per week: Yes \_\_\_\_\_ No \_\_\_\_\_
- d. Less than two hours per day: Yes \_\_\_\_\_ No \_\_\_\_\_
- e. Two to four hours per day: Yes \_\_\_\_\_ No \_\_\_\_\_
- f. Over four hours per day: Yes \_\_\_\_\_ No \_\_\_\_\_

12. During the period you are using the respirator(s), is your work effort:

**Light** (less than 200 kcal per hour): Yes \_\_\_\_\_ No \_\_\_\_\_

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs.

\_\_\_\_\_ mins. Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (one to three lbs.) or controlling machines.

**Moderate** (200 to 350 kcal per hour): Yes \_\_\_\_\_ No \_\_\_\_\_

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs.

\_\_\_\_\_ mins. 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 lbs.) at trunk level; walking on a level surface about two mph or down a five degree grade about three mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

**Heavy** (above 350 kcal per hour): Yes \_\_\_\_\_ No \_\_\_\_\_

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs.

\_\_\_\_\_ mins. Examples of heavy work are lifting a heavy load (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 eight degree grade about two mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective 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 (temperature exceeding 77 degree 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):

\_\_\_\_\_

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):

1. Name of the first toxic substance: \_\_\_\_\_

• Duration of exposure per shift: \_\_\_\_\_

• Estimated maximum exposure level per shift: \_\_\_\_\_

2. Name of the second toxic substance: \_\_\_\_\_

• Duration of exposure per shift: \_\_\_\_\_

• Estimated maximum exposure level per shift: \_\_\_\_\_

3. Name of the third toxic substance: \_\_\_\_\_

• Duration of exposure per shift: \_\_\_\_\_

• Estimated maximum exposure level per shift: \_\_\_\_\_

4. 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 (e.g. rescue or security):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_