Occupational Safety and Health Administration

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employer: Answers to all questions in Part A: Section 1 and question 9 of Section 2, 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 or type).

Today's Date: _____

Name: _____ UID: _____ Date of Birth: _____

Sex (M / F): _____ Height: _____ ft. _____ in. Weight: _____ lbs.

Position (Title): _____

Phone number where the reviewer can reach you (include Area Code): _____

Best time to reach you at phone number above: _____

Has your employer told you how to contact the health care professional who will review this questionnaire? Yes ☐ No ☐

Check the type of respirator you have received approval to use (you can check more than one category):

- ☐ N, R, or P respirator (filtering facepiece, non-cartridge type only such as N95).
- ☐ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you been medically cleared for and worn a respirator in the past? 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 print or type).

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? (Mark all that apply.)
   - ☐ Seizures
   - ☐ Diabetes (sugar disease)
   - ☐ Allergic reactions that interfere with your breathing
   - ☐ Claustrophobia (fear of closed-in places)
   - ☐ Trouble smelling odors
3. Have you ever had any of the following pulmonary or lung problems? (Mark all that apply.)
   - ☐ Asbestosis
   - ☐ Asthma
   - ☐ Chronic bronchitis
   - ☐ Emphysema
   - ☐ Pneumonia
   - ☐ Tuberculosis
   - ☐ Silicosis
   - ☐ Pneumothorax (collapsed lung)
   - ☐ Lung cancer
   - ☐ Broken ribs
   - ☐ Any chest injuries or surgeries
   - ☐ 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? (Mark all that apply.)
   - ☐ Shortness of breath
   - ☐ Shortness of breath when walking fast on level ground or walking up a slight hill or incline
   - ☐ Shortness of breath when walking with other people at an ordinary pace on level ground
   - ☐ Have to stop for breath when walking at your own pace on level ground
   - ☐ Shortness of breath when washing or dressing yourself
   - ☐ Shortness of breath that interferes with your job
   - ☐ Coughing that produces phlegm (thick sputum)
   - ☐ Coughing that wakes you early in the morning
   - ☐ Coughing that occurs mostly when you are lying down
   - ☐ Coughing up blood in the last month

- ☐ Wheezing
- ☐ Wheezing that interferes with your job
- ☐ Chest pain when you breathe deeply
- ☐ 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? (Mark all that apply.)
   - ☐ Heart attack
   - ☐ Stroke
   - ☐ Angina
   - ☐ Heart failure
   - ☐ Swelling in your legs or feet (not caused by walking)
   - ☐ Heart arrhythmia (heart beating irregularly)
   - ☐ High blood pressure
   - ☐ Any other heart problem that you've been told about
6. Have you ever had any of the following cardiovascular or heart symptoms? (Mark all that apply.)
   - ☐ Frequent pain or tightness in your chest
   - ☐ Pain or tightness in your chest during physical activity
   - ☐ Pain or tightness in your chest that interferes with your job
   - ☐ In the past two years, have you noticed your heart skipping or missing a beat
   - ☐ Heartburn or indigestion that is not related to eating
   - ☐ 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? (Mark all that apply.)
   - ☐ Breathing or lung problems
   - ☐ Heart trouble
   - ☐ Blood pressure
   - ☐ Seizures
8. If you've used a respirator, have you ever had any of the following problems? (Mark all that apply. If you've never used a respirator, check the following space and go to question 9.)
   - ☐ Eye irritation
   - ☐ Skin allergies or rashes
   - ☐ Anxiety
   - ☐ General weakness or fatigue
   - ☐ 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? Yes ☐ No ☐

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)? Yes ☐ No ☐

11. Do you currently have any of the following vision problems? (Mark all that apply.)
    - ☐ Wear contact lenses
    - ☐ Wear glasses
    - ☐ Color blind
    - ☐ Any other eye or vision problem

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? (Mark all that apply.)
    - ☐ Difficulty hearing
    - ☐ Wear a hearing aid
    - ☐ Any other hearing or ear problem

14. Have you ever had a back injury? Yes ☐ No ☐

15. Do you currently have any of the following musculoskeletal problems? (Mark all that apply.)
    - ☐ Weakness in any of your arms, hands, legs, or feet
    - ☐ Back pain
    - ☐ Difficulty fully moving your arms and legs
    - ☐ Pain or stiffness when you lean forward or backward at the waist
    - ☐ Difficulty fully moving your head up or down
    - ☐ Difficulty fully moving your head side to side
    - ☐ Difficulty bending at your knees
    - ☐ Difficulty squatting to the ground
    - ☐ Climbing a flight of stairs or a ladder carrying more than 25 lbs
    - ☐ Any other muscle or skeletal problem that interferes with using a respirator

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 of the conditions, listed below? (Mark all that apply.)
   - ☐ Asbestos
   - ☐ Silica (e.g., in sandblasting)
   - ☐ Tungsten/cobalt (e.g., grinding or welding this material)
   - ☐ Beryllium
   - ☐ Aluminum
   - ☐ Coal (for example, mining)
   - ☐ Iron
   - ☐ Tin
   - ☐ Dusty environments
   - ☐ Any other hazardous exposures

   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:

   _____

10. Will you be using any of the following items with your respirator(s)? (Mark all that apply.)
    - ☐ HEPA Filters
    - ☐ Canisters (for example, gas masks)
    - ☐ Cartridges

11. How often are you expected to use the respirator(s)? (Mark all that apply.)

    ☐ Escape only (no rescue)
    ☐ Emergency rescue only
    ☐ Less than 5 hours per week
    ☐ Less than 2 hours per day
    ☐ 2 to 4 hours per day
    ☐ Over 4 hours per day

12. During the period you are using the respirator(s), is your work effort light, moderate, or heavy?

    ☐ Light (less than 200 kcal per hour). Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.

        If "light," how long does this period last during the average shift?
        _____ hrs. _____ mins.

    ☐ Moderate (200 to 350 kcal per hour). 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.).

        If "moderate," how long does this period last during the average shift?
        _____ hrs. _____ mins.

    ☐ Heavy (above 350 kcal per hour). 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.

        If "heavy," how long does this period last during the average shift?
        _____ hrs. _____ mins.

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 deg. 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):

    Name of the first toxic substance: _____

    Estimated maximum exposure level per shift: _____

    Duration of exposure per shift: _____

    Name of the second toxic substance: _____

    Estimated maximum exposure level per shift: _____

    Duration of exposure per shift: _____

    Name of the third toxic substance: _____

    Estimated maximum exposure level per shift: _____

    Duration of exposure per shift: _____

    The names 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 (for example, rescue, security):

    _____

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998; 76 FR 33607, June 8, 2011; 77 FR 46949, Aug. 7, 2012]

https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9783

FLORIDA GULF COAST UNIVERSITY
ENVIRONMENTAL HEALTH & SAFETY

Respirator Medical Recommendation Form

Employee Name (Please print or type): _____

Employer: Florida Gulf Coast University

This form outlines the results of the Occupational Safety and Health Administration (OSHA) Respirator Medical Evaluation and must be completed by a physician or licensed medical provider.

Based on a review of the individual's completed OSHA Respirator Medical Evaluation Questionnaire (Sec. 1910.134, Appendix C), physical examination, and further evaluation as appropriate, this employee is:

(Please Select ONE)

☐ Medically approved for disposable N or P or R, - 95, 99 or 100 filtering facepiece respirator(s) only and subject to satisfactory fit test.

☐ Medically approved for all types of respirator, **except** full-facepiece respirator or a self-contained breathing apparatus (SCBA), and subject to fit test.

☐ Medically approved for all types of respirator, including full-facepiece and self-contained breathing apparatus (SCBA) and subject to fit test.

☐ Not medically approved for respirator use at this time.

(Optional)

☐ And must comply with the following restrictions/limitations for respirator use:

_____

_____

Name of Licensed Medical Provider
(Please print or type): _____

Date: _____ Signature: _____

If you have any questions regarding the completion of this evaluation, please call FGCU Environmental Health and Safety at 239-590-1414.