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Introduction

Respirators must be used in workplaces in which employees are exposed to hazardous airborne contaminants. When respiratory protection is required, employers must have a respirator protection program as specified in OSHA's Respiratory Protection Standard (29 CFR 1910.134). Before wearing a respirator, workers must first be medically evaluated using the mandatory medical questionnaire or an equivalent method.

The requirements of the medical evaluation and for using the questionnaire are provided below:

- The employer must identify a physician or other licensed health care professional (PLHCP) to perform all medical evaluations using the medical questionnaire in Appendix C of the Respiratory Protection standard or a medical examination that obtains the same information. (See Paragraph (e)(2)(i))
- The medical evaluation must obtain the information requested in Sections 1 and 2, Part A of Appendix C. The questions in Part B of Appendix C may be added at the discretion of the health care professional. (See Paragraph (e)(2)(ii).)

Excerpt from Appendix C of 29 CFR 1910.134:

- The employer must ensure that a follow-up medical examination is provided for any employee who gives a positive response to any question among questions 1 through 8 in Part A Section 2, of Appendix C, or whose initial medical examination demonstrates the need for a follow-up medical examination. The employer must provide the employee with an opportunity to discuss the questionnaire and examination results with the PLHCP. (See Paragraph (e)(3)(i).)
- The medical questionnaire and examinations must be administered confidentially during the employee's normal working hours or at a time and place convenient to the employee and in a manner that ensures that he or she understands its content. The employer must not review the employee's responses, and the questionnaire must be provided directly to the PLHCP. (See Paragraph (e)(4)(i).)

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.

Directions for Completion

All questions must be answered unless specifically stated otherwise. This questionnaire is not to be returned to EH&S. Upon completion of this form, the employee must submit this questionnaire the below location (where the medical professional reviewing the questionnaire is located).

Holzer Health Center (Florida Tech)
Phone: 321-674-8078
Email: healthcenter@fit.edu
Website: https://www.fit.edu/health/
Address: 2976 Country Club Road, Melbourne, FL 32901

Part A Section 1. (Mandatory)

To be completed by every employee who has been selected to use any type of respirator.

Date	First Name	Last Name	Job Title
Student ID	Phone Number	Date of Birth	SSN
Age	Sex	Height (ft/inch)	Weight (lbs.)

Denote the type of respirator you will use (you can check more than one category):
☐ Dust/Mist Mask (Disposable) ☐ N95 or N99 Respirator (Disposable) ☐ Half Face Air Purifying Respirator (APR) ☐ Full Face Air Purifying Respirator (APR) ☐ Powered Air Purifying Respirator (PAPR)
Have you ever worn a respirator?
☐ No / ☐ Yes If yes, what type(s)?
Is a respirator required for your tasks or is it voluntary?
☐ Required / ☐ Voluntary

Describe the hazardous conditions you might encounter when wearing your respirator:
Summary of the employee's exposure to a hazardous substance:
Length of time required to wear respirator:
Expected physical work load (light, moderate, or heavy):
Potential temperature and humidity extremes:
Any additional protective clothing required:
How often will you be expected to wear a respirator (days/week and hours/day):

Part A. Section 2. (Mandatory)

To be completed by every employee who has been selected to use any type of respirator.

		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	☐	☐
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?	YES	NO
a.	Asbestosis	☐	☐
b.	Asthma	☐	☐
c.	Chronic bronchitis	☐	☐
d.	Emphysema	☐	☐
e.	Pneumonia	☐	☐
f.	Tuberculosis	☐	☐
g.	Silicosis	☐	☐
h.	Pneumothorax	☐	☐
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?	YES	NO
a.	Shortness of breath	☐	☐
b.	Shortness of breath when walking fast on level ground or walking up a slight hill 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?	YES	NO
a.	Heart attack	☐	☐
b.	Stroke	☐	☐
c.	Angina	☐	☐
d.	Heart failure	☐	☐
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?	YES	NO
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?	YES	NO
a.	Breathing or lung problems	☐	☐
b.	Heart trouble	☐	☐
c.	Blood pressure	☐	☐
d.	Seizures	☐	☐

		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 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 …….	☐	☐
		YES	NO
9	Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	☐	☐

10 Please list any medications (including dosages) that you are currently taking.

Questions 10 to 15

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.

		YES	NO
1	Have you ever lost vision in either eye (temporarily or permanently)?	☐	☐
2	Do you currently have any of the following vision problems?	YES	NO
	a. Wear contact lenses	☐	☐
	b. Wear glasses	☐	☐
	c. Color blind	☐	☐
	d. Any other eye or vision problem	☐	☐
		YES	NO
3	Have you ever had an injury to your ears, including a broken eardrum?	☐	☐
4	Do you currently have any of the following hearing problems?	YES	NO
	a. Difficulty hearing	☐	☐
	b. Wear a hearing aid	☐	☐
	c. Any other hearing or ear problem	☐	☐
		YES	NO
5	Have you ever had a back injury?	☐	☐
6	Do you currently have any of the following musculoskeletal problems?	YES	NO
	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	☐	☐