

Dear Customer,

As your occupational health provider we strive to continue a strong relationship with our valued clients. In an effort to provide these services efficiently, we would like to clarify any confusion while filling out the **Respirator Medical Clearance** form for your employees. This information is critical for the caregiver performing the respirator clearance for your employee.

The top of the form is to be completed by you, the employer:

1. The first information that is requested is the type of respirator that the employee is to wear. This is not the brand or model but whether it is **Air Purifying** or **Atmosphere Supplying**. There are selections under each of those categories as well.
  - a. An **Air Purifying Respirator** is a respirator with an air-purifying filter, cartridge, or canister that removes specific air contaminants by passing ambient air through the air purifying element. Air Purifying Respirators are either Negative Pressure (half face or full face) or N95 Particulate Respirator. Canister respirators protect against certain fumes or gases. N95 Respirators capture particles but do not protect against fumes or gases. Positive pressure air purifying respirators include PAPR's. A PAPR (full face or hood) is a hood or full face with a hose that connects to a power pack worn on the person.
  - b. An **Atmosphere Supplying Respirator** is a breathing device that supplies the wearer with air from a source that is separate from the ambient air, such as from an air tank. Atmosphere Supplying types are Airline (continuous flow), SCBA (positive pressure, pressure demand), open circuit or closed circuit (rebreather), and Combined (airline/SCBA). In open circuit SCBA's, the exhaled air is discarded. This is the typical SCBA worn by fire fighters. In closed circuit SCBA's, the exhaled air is recirculated to provide longer use times. Airline (continuous flow) respirators are air-supplied respirators that make use of a hose to deliver safe air from a stationary source of compressed air. A Self-Contained Breathing Apparatus SCBA consists of a wearable clean-air supply pack.
2. **Level of Work Effort.** Level of work the employee will be doing while wearing the respirator. Choices are Light, Moderate, Heavy and Strenuous.
3. **Extent of Usage.** Will the employee be wearing the respirator on a daily basis? Occasionally, but more than once a week? Or rarely – or for emergency situations only.

4. Length of Time of Anticipated Effort in Hours. This is the length of time that the employee would be expected to wear the respirator.
5. Special Work Considerations. Complete this section if the employee would be wearing the respirator in high places, excessive temperatures, hazardous materials, wearing protective clothing, etc.
6. The final step is to sign the form. The line is titled Company Safety Representative with phone number. This should be who has completed the form.

The rest of the form is for care provider to complete. This form should accompany the **OSHA Mandatory Respirator Medical Evaluation Questionnaire**, which is to be filled out by the employee.

Bring these completed forms to your clinic visit. If you are mailing these forms mail them to the appropriate contact below:

**Frederick Health Employer Solutions Frederick:**  
Practice Manager  
490 Prospect Blvd Suite L  
Frederick MD 21701

**Frederick Health Employer Solutions Howard:**  
Practice Manager  
7165 Columbia Gateway Drive Suite G  
Columbia MD 21046

**Carroll Occupational Health:**  
Practice Manager  
700 Corporate Center Court Suite B  
Westminster MD 21157

**Your Workplace and Your Employees are Our Only Business.**

Frederick Health Employer Solutions

Patient: \_\_\_\_\_ Company: \_\_\_\_\_ Date of Service: \_\_\_\_\_  
Patient ID: \_\_\_\_\_ Contact: \_\_\_\_\_  
Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Form: F-RESPCL Page 1

Respirator Med Clearance Form

Please check Type(s) of Respirator(s) to be used:

Air Purifying:

- Negative Pressure (half face or full face)
- PAPR (full face or hood)
- N95 Particulate Respirator

(rebreather)

Atmosphere Supplying:

- Airline (continuous flow)
- SCBA (positive pressure, pressure demand)
  - open circuit
  - closed circuit

Combined (airline/SCBA)

Level of Work Effort:  Light  Moderate  Heavy  Strenuous

Extent of Usage:

- On a daily basis
- Occasionally - but more than once a week
- Rarely - or for emergency situations only

Length of Time of Anticipated Effort in Hours: \_\_\_\_\_

Special Work Considerations: (i.e. high places, temperature, hazardous material, protective clothing, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Safety Representative/Supervisor

\_\_\_\_\_  
Telephone Number

-----  
Health Care Provider's Evaluation  
\_\_\_\_\_  
\_\_\_\_\_

Class (check one):

- No restrictions on respirator use
- Some specific use restrictions
- No respirator use permitted
- Need special frames for glasses if required to wear full-face respirator
- No contact lenses

Restrictions:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
 FIT TEST TECHNICIAN HAS CONFIRMED THAT FACIAL HAIR IS NOT PRESENT ACROSS RESPIRATOR SEAL AREAS AT THE TIME OF TESTING (OSHA REG 29 CFR 1910.134)

\_\_\_\_\_  
Health Care Provider Signature  
f-respcl

\_\_\_\_\_  
Date

**Frederick Health Employer Solutions**

Phone: 240-566-3001

Patient Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Company: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_

Age: \_\_\_\_\_

Form: F-RESHXM

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**RESPIRATOR QUESTIONNAIRE**

OSHA Mandatory Respirator Medical Evaluation Questionnaire  
29 CFR 1910.134

Can you read:  yes  no

Your employer must allow you to answer the questionnaire during normal working hours, or at a time 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: \_\_\_\_\_
4. Your Job Title: FIREFIGHTER AND/OR EMT
5. Your Date of Birth: \_\_\_/\_\_\_/\_\_\_
6. Sex  Male  Female
7. Your Height: \_\_\_ feet \_\_\_ inches
8. Your Weight: \_\_\_ lbs.
9. Phone # where you can be reached to discuss your answers: (\_\_\_\_\_) \_\_\_\_\_
10. The best time to call you at this number: \_\_\_\_\_  
 a.m.  p.m.
11. Has your employer told you how to contact the health care professional who will review this questionnaire?  yes  no
12. 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).
13. Have you worn a respirator?  yes  no  
If yes, what type(s):  
OPEN CIRCUIT SCBA  
-----

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.

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. Trouble smelling odors:  yes  no
  - d. Claustrophobia (fear of closed-in places)  yes  no
  - e. Allergic reaction that interfere with your breathing?  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 you've been told about  yes  no

Patient Name:

Social Security #:

Company:

Date of Service:

Birthdate: \_\_\_/\_\_\_/\_\_\_

Age: \_\_\_

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### RESPIRATOR QUESTIONNAIRE

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. Swelling in your legs and feet (not caused by walking)  yes  no
  - e. Heart Failure  yes  no
  - f. Heart arrhythmia (irregular heart beat)  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 the 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 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 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 the following box and go to question 9.  Never Used
- 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

**Frederick Health Employer Solutions**  
**Phone: 240-566-3001**

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Company: \_\_\_\_\_ Date of Service: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Form: F-RESHXM

**RESPIRATOR 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):  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 you 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 you arms & 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 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.

- 1. In your present job, are you working at high altitudes (over 5,000 ft) 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: \_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Company: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Form: F-RESHXM

### RESPIRATOR QUESTIONNAIRE

3. Have you ever worked with any of the materials, or under any of the conditions listed below:
- |                                   |                          |     |                          |    |
|-----------------------------------|--------------------------|-----|--------------------------|----|
| a. Asbestos:                      | <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
| b. Silica:                        | <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
| c. Tungsten/Cobalt:               | <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
| d. Beryllium:                     | <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
| e. Aluminum:                      | <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
| f. Coal:                          | <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
| g. Iron:                          | <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
| h. Tin:                           | <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
| i. Dusty environments:            | <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
| j. Any other hazardous exposures: | <input type="checkbox"/> | yes | <input type="checkbox"/> | no |
- If 'yes' describe the exposure:
4. List any second jobs or side businesses you have:
5. List your previous occupations:
6. List your current & previous hobbies:
7. Have you been in the military service?  yes  no  
If 'yes' describe these exposures:
8. Have you ever worked on a HAZMAT team?  yes  no
9. Other than the 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:

Patient Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Company: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_

Age: \_\_\_\_\_

Form: F-RESHXM

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### RESPIRATOR QUESTIONNAIRE

10. Will you be using any of the following items with your respirator(s)?

- a. HEPA Filters  yes  no
- b. Canisters (e.g. gas masks)  yes  no
- c. Cartridges  yes  no

11. How often are you expected to use the respirator:

- a. Escape only; no rescue  yes  no
- b. Emergency rescue only  yes  no
- c. Less than 5 hours per week  yes  no
- d. Less than 2 hours per day  yes  no
- e. 2 to 4 hours per day  yes  no
- f. Over 4 hours per day  yes  no

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

- a. Light (less than 200 kcal per hour):  yes  no  
If 'yes', how long does this period last during the average shift  
\_\_\_\_\_ hours \_\_\_\_\_ minutes

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.

- b. Moderate (200 to 350 kcal per hour)  yes  no  
If 'yes', how long does this period last during the average shift  
\_\_\_\_\_ hours \_\_\_\_\_ minutes

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 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

- c. Heavy (above 350 kcal per hour):  yes  no  
If 'yes', how long does this period last during the average shift  
VARIABLE hours \_\_\_\_\_ minutes

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 8-degree grade about 2 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 the respirator:  yes  no

If 'yes' describe this protective clothing and/or equipment:  
STRUCTURAL FIREFIGHTING TURNOUT GEAR

14. Will you be working under hot conditions (temperature exceeding 77 degrees F)  yes  no

15. Will you be working under humid conditions:  yes  no POSSIBLE

16. Describe the work you'll be doing while you're using your respirator(s):  
INTERIOR STRUCTURAL FIREFIGHTING



Frederick Health Employer Solutions  
Phone: 240-566-3001

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Company: \_\_\_\_\_ Date of Service: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Form: F-RESHXM

**RESPIRATOR QUESTIONNAIRE**

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (e.g., confined spaces, life-threatening gases):  
HAZARDS ASSOCIATED WITH INTERIOR STRUCTURAL FIREFIGHTING

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 toxic substance - #1: SPECIFIC SUBSTANCES UNKNOWN OR  
Estimated maximum exposure level per shift: VARIABLE BY SITUATION  
Duration of exposure per shift: \_\_\_\_\_

Name of toxic substance - #2:  
Estimated maximum exposure level per shift:  
Duration of exposure per shift: \_\_\_\_\_

Name of toxic substance - #3:  
Estimated maximum exposure level per shift:  
Duration of exposure per shift: \_\_\_\_\_

Name of toxic substance - #4:  
Estimated maximum exposure level per shift:  
Duration of exposure per shift: \_\_\_\_\_

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, security)  
WILL WORK AS PART OF A FIREFIGHTING TEAM; MAY EFFECT RESCUE OPERATIONS

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

OSHA Mandatory Respirator Medical Evaluation Questionnaire Reviewed by:

\_\_\_\_\_  
PLHCP Signature  
f-reshxm

\_\_\_\_\_  
Date