

## Industrial Hearing & Pulmonary Management

### RESPIRATOR MEDICAL EVALUATION CERTIFICATION

**Employee Identification:**

Employee's Name:	Employee ID Number:
Department/Location:	Job Title: Energy Tech
Type of Respirator:	Frequency of Use:
Date of Medical Evaluation:	
Cleared Medical Evaluation expires 1yr from above date	

**Medical Evaluator Contact Information:**

Name:	<b>Sunil K. Saini, MD</b>
Street Address:	<b>1846 Woodlawn Street</b>
City, State, Zip:	<b>Upland, CA. 91786</b>
Phone:	<b>(909) 982-0579</b>

After reviewing the medical history, job description, type of respirator, frequency of use, potential exposures, and any additional information (PFT test results), it is my opinion that:

- The employee is medically qualified to wear a respirator without limitation
- The employee is **NOT** medically qualified to wear a respirator  
I have explained the evaluation results to the employee and provided him/her with a copy.
- The employee is medically qualified to wear a respirator, however, further  
Medical Evaluation is indicated within the following parameters:

- 
- 
- The employee may only wear a respirator with the following limitation(s):
- 
- 
- 

\_\_\_\_\_  
Signature of Reviewing Physician or (PLHCP)

\_\_\_\_\_  
Date

Physician or (PLHCP) Printed Name: **Sunil K. Saini M.D.**

This form must be completed and a copy sent to requesting Employer before an employee will be fit-tested for a respirator and trained.

## OSHA Respirator Medical Evaluation Questionnaire

*The Company agrees that any and all information obtained in this OSHA Respirator Medical Evaluation Questionnaire shall be used for the sole purpose of determining an employee's ability to use a respirator. The Company further agrees that any information obtained in this OSHA Respirator Medical Evaluation Questionnaire will not be used for disciplinary purposes.*

Dear Employee:

The attached medical questionnaire is a mandatory form required by Cal-OSHA, and is used by a health care professional to evaluate your ability to wear a respirator. Please read your rights concerning this questionnaire, and follow the instructions below. Thank you for your cooperation!

### **Employee Rights:**

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.

### **Instructions:**

1. Complete the attached medical evaluation questionnaire.
2. Complete the questionnaire **only in pen**, blue or black ink.
3. If you have questions about the questionnaire, or would like to talk with the health care professional who reviews it, please contact **Industrial Hearing and Pulmonary Management (IHPM) at (909) 982-0579**. (Note: IHPM is an occupational health care consulting and outsourcing firm the Company has contracted with for the medical portion of the Respiratory Protection Program.)
4. Place the completed questionnaire in the stamped, **Confidential** envelope provided by your supervisor, and send it to: IHPM at 1846 Woodlawn Street, Upland, CA 91786 or fax it to (909)752-6152 Attn: Alex.
5. You may be contacted by the health care professional who reviews this questionnaire regarding your answers to this questionnaire, or for a follow-up physical examination.

## OSHA Respirator Medical Evaluation Questionnaire

Can you read? (Circle one): Yes No

### Part A. Section 1.

Please print.

1. Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Your name: \_\_\_\_\_

Employee identification number: \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

3. Your age (to nearest year): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

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 will review  
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): \_\_\_\_\_  
\_\_\_\_\_

13. Your supervisor's name: \_\_\_\_\_

14. Your supervisor's phone number(include the Area Code): (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### Part A. Section 2.

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 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. What was your last blood pressure reading? \_\_\_\_\_
8. 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. List any medications you are currently taking \_\_\_\_\_
9. 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: .....  | 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 |
10. Would you like to talk to the health care professional who will review this questionnaire  
 about your answers to this questionnaire: ..... Yes No
11. Have you **ever lost** vision in either eye (temporarily or permanently): ..... Yes No
12. 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 |
13. Have you **ever had** an injury to your ears, including a broken ear drum: ..... Yes No

14. 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
15. Have you **ever had** a back injury: ..... Yes No
16. 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 lbs: ..... Yes No
  - j. Any other muscle or skeletal problem that interferes with using a respirator: ..... Yes No

**Part B**

1. 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. List any second jobs or side businesses you have:  
\_\_\_\_\_  
\_\_\_\_\_
3. List your current and previous hobbies:  
\_\_\_\_\_  
\_\_\_\_\_
4. 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
5. Have you ever worked on a HAZMAT team? ..... Yes No
6. How often are you expected to use respirator(s)?  
(Circle "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 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
7. During the period you are using the respirator(s), is your work effort:
- a. **Light:** ..... Yes No  
If "yes," how long does this period last during the average shift: \_\_\_ hrs. \_\_\_ mins.  
(Examples of a light work effort are **sitting**, performing light assembly work, **standing** while spray painting, or controlling machines.)
- b. **Moderate:** ..... Yes No  
If "yes," how long does this period last during the average shift: \_\_\_ hrs. \_\_\_ mins.  
Examples of moderate work effort are **standing** while performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; **walking** on a level surface or down hill; **crawling**; or **pushing** a heavy load (about 100 lbs.) on a level ground.
- c. **Heavy:** ..... 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; **shoveling**; **standing** while operating heavy pneumatic equipment, or **walking** up hill.
8. 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: \_\_\_\_\_  
\_\_\_\_\_
9. Will you be working under hot or humid conditions? ..... Yes No
10. Have you had any health problems related to working in hot or humid environments? ..... Yes No
11. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases, or high altitudes over 5,000 feet): \_\_\_\_\_  
\_\_\_\_\_
12. What type of respirator(s) do you wear? (Circle "Yes" or "No" for all that apply)
- a. Self-contained breathing apparatus (SCBA) ..... Yes No  
b. Air line (Air line cylinder, or *new* truck compressor air panel system) ..... Yes No  
c. Half-face disposable cartridge (3M 6000) ..... Yes No  
d. Escape only ..... Yes No