Illinois State University Respiratory Protection Program Medical Evaluation and Determination for Respirator Users (Non-HAZMAT)

Employees need to be medically cleared to wear respirators before commencing use. All respirators generally place a burden on the employee and may adversely affect the health of some employees who wear respirators. A physician or other licensed health care professional operating within the scope of his/her practice needs to medically evaluate employees to determine under what conditions they can safely wear respirators.

Illinois State University Student Health Services provides medical questionnaire reviews and evaluations for employees who wear respirators. In order to wear a respirator, each affected employee must complete the attached Medical Evaluation Questionnaire and Medical Determination Forms. *NOTE: Part B of the Medical Evaluation Questionnaire is not mandatory. Only complete this section if requested by the physician.*

Once a physician reviews and approves respirator use, the employee will need to be fit tested and trained by Environmental Health and Safety. Medical evaluations are good for 3 years; respirator fit tests and training must be completed annually.

Complete the medical evaluation questionnaire and medical determination forms and submit via campus mail to:

ISU Student Health Services

Attn: Respirator User Evaluation

Campus Box 2540

If you have questions regarding the process for respirator selection, fit testing, and/or training, contact:

ISU Environmental Health and Safety

438-8325

sysenvironmental@ilstu.edu

Medical Evaluation Questionnaire from 1910.134, Appendix C

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 for you. To maintain your confidentiality, your employer or supervisor must not see your answers. Your employer will tell you how to deliver 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 (*to nearest year*):
4. Sex (*check one*): ☐ Male ☐ Female
5. Your height: feet inches
6. Your weight: pounds
7. Your job title:
8. A phone number where you can be reached by the health-care professional who reviews this questionnaire (*Include 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? (*Check one.*) ☐ Yes ☐ No
11. 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).
    - ☐ Other type (for example, half- or full-facepiece type, powered air-purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator? (*Check one.*) ☐ 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. (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. Chest injuries or chest 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. Do you have to stop for breath when walking at your own pace on level ground..... ☐ Yes ☐ No

e. Do you have shortness of breath when washing or dressing yourself..... ☐ Yes ☐ No

f. Do you have shortness of breath that interferes with your job..... ☐ Yes ☐ No

g. Do you have coughing that produces phlegm (thick sputum) ..... ☐ Yes ☐ No

h. Do you have coughing that wakes you early in the morning ..... ☐ Yes ☐ No

i. Do you have coughing that occurs mostly when you are lying down..... ☐ Yes ☐ No

j. Have you coughed up blood in the last month ..... ☐ Yes ☐ No

k. Do you wheeze ..... ☐ Yes ☐ No

l. Do you have wheezing that interferes with your job..... ☐ Yes ☐ No

m. Do you have chest pain when you breathe deeply..... ☐ Yes ☐ No

n. Do you have 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 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've used a respirator, have you ever had any of the following problems? (*If you've never used a respirator, 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

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 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 ear drum ☐ 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 your arms, hands, legs, or feet ☐ Yes ☐ No

b. Back pain ☐ Yes ☐ No

c. Difficulty 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 pounds ☐ Yes ☐ No

j. Any other muscle or skeletal problem that interferes with using a respirator ☐ Yes ☐ No

Part B (Non-Mandatory)

Any of the following questions as well as questions not listed here 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:

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 ..... ☐ Yes ☐ No

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)?

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 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 ..... ☐ 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; standing while operating a drill press (1-3 lbs.) controlling machines.

b. Moderate ..... ☐ 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 ..... ☐ Yes ☐ No

If yes, how long does this period last during the average shift; 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 your respirator? ..... ☐ Yes ☐ No

If yes, describe this protective clothing and/or equipment:

14. Will you be working under hot conditions? (*temperature exceeding 77°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:

• Name of any other toxic substances 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, or security*):

Medical Determination for Respirator Use

Respirator Usage [1910.134]

Part I: (Information below this block to be completed by supervisor or EHS)

Name:	
UID:	DOB:
Department:	Age:
Job Classification:	Today's Date:

Type of Respirator Used – check and circle all that apply

☐ Filtering Face Piece (Particulate, Disposable, Single Use, Dust Mask)

☐ Half Face (Filter, Chemical, Cartridge, Combination Chemical and Cartridge)

☐ Full Face (Filter, Chemical, Cartridge, Combination Chemical and Cartridge)

☐ Powered Air Purifying

☐ Supplied Air Respirator with back up ☐ Supplied Respirator without Backup

☐ Self-Contained Breathing Apparatus (SCBA)

Level of Work Effort

☐ Light – Ex. Sitting, standing using 1-3 # drill

☐ Moderate – Ex. Assembly work standing, driving, pushing 100 lbs., carrying 35 lbs.

☐ Heavy – Ex. Lifting 50 lbs., climbing with 50 lbs., walking up an 8° grade at 2 mph.

☐ Strenuous – More than heavy

Extent of Usage

☐ Daily ☐ Weekly ☐ Less than once a week ☐ Rarely ☐ Emergency

Estimated Length of Use of Time Used per Session _____hrs _____minutes or _____hrs per day

Special Work Conditions:

☐ Special need for visual or auditory acuity ☐ High places ☐ Confined spaces

☐ High temperature ☐ Additional protective equipment required ☐ Other: _____

Part II: (To Be Completed By Physician)

☐ **No Restrictions on Respirator Use**	☐ **Temporarily Not Qualified**	☐ **Not Qualified**
Print:		
Sign:		
Date:		

The employee and employer have been provided with a copy of this determination by either mail or fax.

PHYSICIAN: PLEASE PROVIDE A COPY TO THE PATIENT AND FORWARD A COPY TO EHS @ CAMPUS BOX 1320 or FAX 438-3086