GENERAL INFORMATION

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, employees must first be medically evaluated using the mandatory medical questionnaire.

Medical Evaluation and Questionnaire Requirements

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 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).)
- 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 health care professional. (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 health care provider by the employee.** (See Paragraph (e)(4)(i).)

Excerpt from Appendix C of 29 CFR 1910.134: OSHA Respirator Medical Evaluation Questionnaire

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.

PART A – Section 1.0 (Mandatory)

The following information must be provided by the employee who is required to use any type of respirator as part of their job related duties.

1. Employee name:			2. Today's date:				
3. Age (nearest year):			4. Gender:	☐	Male	☐ Female	☐ G-Neutral
5. Height:	Feet	Inches	6. Weight (pounds):				
7. Job Title:			8. Department:				
9. E-mail:			10. Telephone:				

11. Complete the below by requesting information from EHS on **how** to contact the health care professional **who** will review this questionnaire.

☐	Urgent Care (EHS Website – Approved Providers)	☐	Student Health & Counseling (828-251-6520)
☐	Other provider, please specify:		

12. Best time for the reviewer to call?	Date:		AM	PM

13. Check the type of respirator you will use (you can check more than one category):

Disposable respirator (filter-mask, non-cartridge type only):		☐	N series	☐	R series	☐	P series
Other type:	☐ Full- or half-face cartridge type	☐	Powered-air purifying	☐	Supplied-air		
	☐ Self-contained breathing apparatus	*Fit testing is required, contact the EHS Professional.*					

14. Have you ever worn a respirator before?	☐	Yes	☐	No
If YES, what type(s):				

PART A – Section 2.0 (Mandatory)

Questions 1 through 9 below must be answered by the employee who is required to use any type of respirator as part of their job related duties.

1. Do you <u>currently</u> smoke tobacco, or have you smoked tobacco in the last month?	☐	Yes	☐	No
2. Have you <u>ever</u> had any of the following conditions?				
a. Seizures	☐	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

PART A – Section 2.0 (Mandatory) CONTINUED				
3. Have you ever had any of the following pulmonary or lung problems?				
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 <u>currently</u> 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 <u>ever</u> 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

PART A – Section 2.0 (Mandatory) CONTINUED				
5. Have you ever had any of the following cardiovascular or heart problems?				
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 currently take medication for any of the following problems?				
a. Breathing or lung problems	☐	Yes	☐	No
b. Heart trouble	☐	Yes	☐	No
c. Blood pressure (high or low)	☐	Yes	☐	No
d. Seizures	☐	Yes	☐	No
8. If you've worn a respirator, have you ever had any of the following problems?				
If you've never worn a respirator, check the space to the right and go to Question 9.	☐	Never		
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? If yes, please send the form electronically to the reviewer when completed.	☐	Yes	☐	No

FOR HEALTH CARE PROFESSIONAL REVIEWER ONLY:	
Reviewer Name:	Date of Review:
Job Title:	Institution:
Reviewer Comments (For Employee Only):	

PART A – Section 2.0 (Mandatory) CONTINUED				
Questions 10 to 15 below must be answered by the employee who is required to use either full-face respirator or a self-contained breathing apparatus (SCBA) as part of their job related duties. For employees, who are required to use other types of respirators, these questions are 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 prescription 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 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 ear or hearing 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 your arms and legs	☐	Yes	☐	No
d. Pain and stiffness when you lean forward or backward at the waist	☐	Yes	☐	No
e. Difficulty 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
FOR HEALTH CARE PROFESSIONAL REVIEWER ONLY:				
This questionnaire does not include the questions in Part B because they are not mandatory; rather they may be added at the discretion of the health care professional if applicable. Please request the Part B form from EHS.				
If the employee's answers to Part A require a more in depth medical review, where Part B would be useful, please indicate whether Part B will be completed.	☐	Yes	☐	No