Respiratory Clearance Program

Dear Employer:

Thank you for choosing Southcoast Occupational Health to complete Respirator Clearance Evaluations on your employees.

Attached to this letter are an OSHA Respirator Evaluation and the OSHA Medical Evaluation Questionnaire for each employee requested.

It is necessary prior to the actual physical examination that the following occurs:

1. The employee’s supervisor or designee completes Section 1 of the OSHA Respiratory Evaluation

2. The employee completes the OSHA Medical Evaluation Questionnaire confidentially.

3. Both forms are to be returned to our Occupational Health department for review by the medical provider.

- If the medical provider reviews the OSHA Questionnaire and finds that no physical evaluation is necessary, the medical provider will complete section II of the OSHA Respiratory Evaluation. This will indicate any recommendations regarding the employee’s ability to use a respirator. A copy of this completed evaluation will be returned to you.

- If the medical provider reviews the OSHA Questionnaire and finds that a physical examination is necessary, then we will contact you to schedule an appointment for the exam.

After the physical examination is complete and the recommendations regarding the employee’s ability to use a respirator are determined, we will return a copy of the OSHA Respirator Evaluation to you. Section II of this form will be completed and will indicate to you the recommendations regarding the employee’s ability to use a respirator.

Thank you,
Southcoast Occupational Health

St. Luke’s Hospital
New Bedford
Phone 508-961-5469
Fax 508-961-5472

Charlton Memorial Hospital
Fall River
Phone 508-679-7044
Fax 508-679-7667
N95 Medical Evaluation Questionnaire: (29 CFR 1910.134)

This questionnaire is in compliance with 29 CFR 1910.134, Appendix C.

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. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Today's date: __________________________

1. Your name: __________________________

2. Date of Birth: ____/____/____

3. Sex (circle): Male/Female

4. Your height: _______ ft. _______ in.

5. Your weight: _______ lbs.

6. Your job title: ______________________

7. Current Employer: Southcoast Hospitals Group Site: ______

8. Home Phone: ( )-_________ ext. ______

9. Work Phone: ( )-_________ ext. ______

10. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): ( )-_________ ext. ______

11. The best time to phone you at this number: ______________________

12. Has your employer told you how to contact the health care professional who will review this questionnaire?

[ ] Yes [ ] No

13. The type of respirator you will use: [ ] N95

14. Have you worn a respirator? [ ] Yes [ ] No

   If "Yes", what type? __________________________

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 (please circle “Y” for Yes or “N” for No).

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Y/N

2. Have you ever had any of the following conditions?
   a. Seizures (fits) Y/N
   b. Diabetes (sugar disease) Y/N
   c. Allergic reactions that interfere with your breathing Y/N
   d. Claustrophobia (fear of closed-in places) Y/N
   e. Trouble smelling odors Y/N

3. Have you ever had any of the following pulmonary or lung problems?
   a. Asbestosis Y/N
   b. Asthma Y/N
   c. Chronic bronchitis Y/N
   d. Emphysema Y/N
   e. Pneumonia Y/N
   f. Tuberculosis Y/N
   g. Silicosis Y/N
   h. Pneumothorax (collapsed lung) Y/N
   i. Lung cancer Y/N
   j. Broken ribs Y/N
   k. Any chest injuries or surgeries Y/N
   l. Any other lung problem that you've been told about Y/N
4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath  Y/N
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline  Y/N
   c. Shortness of breath when walking with other people at an ordinary pace on level ground  Y/N
   d. Have to stop for breath when walking at your own pace on level ground  Y/N
   e. Shortness of breath when washing or dressing yourself  Y/N
   f. Shortness of breath that interferes with your job  Y/N
   g. Coughing that produces phlegm (thick sputum)  Y/N
   h. Coughing that wakes you early in the morning  Y/N
   i. Coughing that occurs mostly when you are lying down  Y/N
   j. Coughing up blood in the last month  Y/N
   k. Wheezing  Y/N
   l. Wheezing that interferes with your job  Y/N
   m. Chest pain when you breathe deeply  Y/N
   n. Any other symptoms that you think may be related to lung problems  Y/N

5. Have you ever had any of the following cardiovascular or heart problems?
   a. Heart attack  Y/N
   b. Stroke  Y/N
   c. Angina  Y/N
   d. Heart failure  Y/N
   e. Swelling in your legs or feet (not caused by walking)  Y/N
   f. Heart arrhythmia (heart beating irregularly)  Y/N
   g. High blood pressure  Y/N
   h. Any other heart problem that you’ve been told about  Y/N

6. Have you ever had any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in your chest  Y/N
   b. Pain or tightness in your chest during physical activity  Y/N
   c. Pain or tightness in your chest that interferes with your job  Y/N
   d. In the past two years, have you noticed your heart skipping or missing a beat  Y/N
   e. Heartburn or indigestion that is not related to eating  Y/N
   f. Any other symptoms that you think may be related to heart or circulation problems  Y/N

7. Do you currently take medication for any of the following problems?
   a. Breathing or lung problems  Y/N
   b. Heart trouble  Y/N
   c. Blood pressure  Y/N
   d. Seizures (fits)  Y/N

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  Y/N
   b. Skin allergies or rashes  Y/N
   c. Anxiety  Y/N
   d. General weakness or fatigue  Y/N
   e. Any other problem that interferes with your use of a respirator  Y/N

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?  Y/N

<table>
<thead>
<tr>
<th>Employee Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Use Only</td>
<td>Restrictions/Remarks</td>
</tr>
<tr>
<td></td>
<td>Physician/Evaluator’s Signature/Date</td>
</tr>
</tbody>
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N95 Respirator Medical Evaluation Questionnaire
OSHA RESPIRATOR EVALUATION

Employee’s Name: ______________________________   ID Number: ______________________________

Company: ______________________________________

Section I: Completed by Supervisor (Print Name) _____________________________________________

Type of Respirator(s): __________________________ Weight of Respirator(s): ______________________

Frequency of use: □ Daily  □ Weekly  □ Monthly  □ Infrequently

Duration of use: □ < 30 minutes □ 30 – 60 minutes □ 1 – 2 hrs □ 2 – 4 hrs □ > 4 hrs

Hazard: ______________________________________ Oxygen Deficient Environment: □ Yes □ No

Atmosphere Immediately Dangerous to Life or Health (IDLH): □ Yes □ No

Expected Physical Work: □ Light □ Moderate □ Heavy

Additional protective clothing or equipment to be worn: _______________________________________

Temperature or humidity extremes that may be encountered: □ None □ Temp > 80°F □ Humidity > 70%

Supervisor: __________________________________ Date: ______________________________

Section II: To be completed by Occupational Health Service

Recommendations Regarding Employee’s Ability to Use a Respirator

Practitioner completed: □ Review of OSHA Medical Questionnaire

□ Respiratory Clearance Examination

1. The employee is medically able to use the respirator indicated above: □ Yes □ No

2. If yes, are there any limitations on respirator use? □ Yes □ No

   If yes, state limitations:

   □ Rescue use only □ Emergency evacuation only

   □ Glass adaptive device required □ Hearing aid required with mask

   □ Facial hair may preclude a tight fit □ Other: ______________________________________

3. □ The employee may not use a negative pressure respirator, but may use a powered air purifying respirator (PAPR) because of ______________________________________.

4. The next regularly scheduled medical evaluation is in □ 1 year □ 2 years □ 3 years □ 5 years

5. Additional follow-up medical evaluations are needed if:

   a. The employee reports signs or symptoms that are related to ability to use a respirator.

   b. Observations made during fit testing or program evaluation indicate a need for re-evaluation.

   c. A change occurs in the job that may require a substantial increase in the workload to be done while wearing the respirator.

   d. A supervisor, Safety Officer or Employee Health feel the employee needs to be re-evaluated.

6. The employee has been given a copy of these recommendations.

Signature __________________________________ Date ______________________________