

MARICOPA COUNTY COMMUNITY COLLEGE DISTRICT

Respiratory Safety Program

March 1, 2013

I. PURPOSE

Is it the intent of this written program to describe respirator safety procedures for MCCCCD and provide guidance for selection, medical testing and proper fit for the use of any respirator, as defined by the manufacturers.

II. DEFINITIONS

Air Purifying Respirator: A respirator with an air purifying filter, cartridge or canister that removes specific air contaminants by passing ambient air through the air purifying element.

Atmosphere Supplying Respirator: A respirator that supplies the user with breathable air from a source independent of the ambient atmosphere and includes supplied air respirators (SARs) and self-contained breathing apparatus (SCBA) units.

Filter Or Air Purifying Element: A component using in respirators to remove solid or liquid aerosols from the inspired air (air being inhaled with high oxygen content).

Filtering Facepiece: Is a negative pressure particulate respirator with a filter as an integral part of the facepiece or with entire facepiece composed of the filtering medium.

Fit Test: Use of a protocol to qualitatively or quantitatively evaluate the fit of a respirator on an individual.

Respirator: A negative pressure, tight-fitting device, as defined by the Occupational Safety and Health Administration (OSHA), in which the air pressure inside the facepiece is negative during inhalation with respect to the ambient air pressure outside the respirator. The user is able to effectively seal the mask when inhaling thus forcing the contaminated air through the filter medium on the inlet of the mask.

Respirator Program Coordinator: A person at the college who is responsible for assisting the College President with the implementation of this written respiratory protection program and ensuring employees who are required to use respirators receive the medical evaluation, fit testing and training prior to using a respirator in accordance with OSHA regulation 29 CFR 1910.134.

III. RESPONSIBILITIES

- A. The College President is responsible to support this written standard, provide resources and personnel necessary to ensure compliance and annually verify the provisions contained herein are adhered to by all employees. Additionally, the College President will ensure employees

affected by this standard received the necessary training and resources to comply with this program and will appoint a Respirator Program Coordinator for their college in writing.

- B. Supervisors are responsible for performing the following actions:
1. Ensure employees required to use respirators are wearing the approved respirator protection for the hazard(s) they encounter and for which they have been fit tested and trained.
 2. Advise all respirator wearers they should safety leave the hazardous (immediate) area any time for relief from respirator use in the event of equipment malfunction, physical or psychological distress, procedural or communication failure, significant deterioration of operating conditions or any other conditions that may warrant such relief.
 3. Ensure employees have received the necessary medical evaluations, training and fit testing required per OSHA (29 CFR 1910.134) before engaging in workplace operations requiring the use of a respirator.
 4. Notify the Respirator Program Coordinator when a new employee requires fit testing or current employees have a change affecting their wear of respiratory protection.
 5. Maintain and enforce the written program in accordance with Federal and State laws by performing an annual review to ensure compliance for their employees needing respiratory protection.
 6. Ensure initial and periodic respiratory protection training is given to all employees in their charge who need to wear a respirator. Additionally, they will assist in the maintaining of training records by the Respirator Program Coordinator.
- C. Employees who wear respiratory protection are responsible to perform the following actions:
1. Complete an initial respirator medical questionnaire and other physical examination requirements as needed prior to performing duties requiring respiratory protection.
 2. Use the provided respiratory protection according to the instructions and training received.
 3. Guard issued respirators against damage; do not use if unsanitary, damaged or unserviceable and turn the respirator in to their supervisor for replacement.
 4. Annually review their medical questionnaire and report to their supervisor any changes in medical status which may impact their ability to safely wear respiratory protection (i.e. significant weight changes, facial scarring, significant dental changes, cosmetic surgery, disfigurement, etc.).
 5. Inspect, clean and maintain any respiratory protection issued to them for their individual use.
 6. Receive initial and, thereafter, annual training and annual fit testing (if needed).
 7. Wear only respiratory protection for which they have received fit testing and training and only for the tasks specified requiring respirator use.
 8. Read and understand the Material Safety Data Sheet (MSDS) or Safety Data Sheet (SDS) for chemicals being using on their job or task.
 9. Ask their supervisor if respirator use is required for their work environment.

- D. Respirator Program Coordinator is responsible for performing the following actions:
1. Take primary responsibility for the implementation of this written program and the procedures contained herein for the college.
 2. Assist supervisors to determine if respiratory protection is required for specific tasks and/or employees.
 3. Ensure a procedure is in place for the ordering and issuing of respirators.
 4. Develop an appropriate respirator cartridge change-out schedule based on manufacturer recommendations and if warranted for a specific type of respirator.
 5. Maintain or have immediate access to the most current version of applicable OSHA standards with regard to respirators.
 6. Ensure proper fit testing is conducted according to 29 CFR 1910.134 for those individuals who have been medically cleared by a physician or licensed health care provider to wear and use.
 7. Review and update, if needed, the respiratory protection program annually.

IV. TRAINING

Employees in the respiratory protection program and supervisors who manage these employees will receive initial, and thereafter annual, refresher training which will include:

- A. Review of the Respirator Identification Presentation and the OSHA Respirator Standards document available from the Respirator Program Coordinator.
- B. Additional training requirements for respirators with a rating greater than N95/N99 or with a more restrictive air flow system. Contact the Respirator Program Coordinator for questions regarding these additional training requirements.

V. PURCHASING OF CERTIFIED RESPIRATORS

Only National Institute for Occupational Safety and Health (NIOSH) approved respirators will be purchased and used by college employees. Supervisors will ensure employees who are required to wear respirators have the correct size.

VI. INVENTORY CONTROL

All employees participating in the respiratory protection program will ensure no outside or uncertified respirators are brought into and used within the course of duty no otherwise recognized by this document. Employees are obligated to report any unauthorized respirator usage to the Respirator Program Coordinator.

VII. ISSUANCE OF RESPIRATORS

All employees who meet the medical requirements, have successfully passed the fit test and have been trained on the provisions of this respiratory protection program will be issued a certified respirator by

their supervisor. Supervisors must monitor and track their employees to ensure compliance with this policy.

VIII. SPECIAL ISSUES

Employees in the respiratory protection program must be aware they will not be allowed to maintain any facial hair beyond what they had at the time of a successful fit test. It is highly recommended the employee maintain no facial hair while required to use a respirator in order to ensure a proper fit and maximum benefit of the respirator.

IX. RESPIRATOR SELECTION

- A. Required Usage: A respirator will be worn at all times when the employee is in the presence of an inhalation hazard. The most common used respirator will be the N95/N99 rated respirator and will be frequently used in the presence of aerosol biohazards common when performing tasks in a maintenance and/or construction environment. Examples of known biohazards that are or are quickly become aerosolized are: Plague, Rabies and Hanta Virus.

- B. Limitations:
 - 1. Personnel will wear all respirators in accordance with the annual respirator fit test.
 - 2. Respirators will be used as directed and for no other types of exposures.
 - 3. The respirator is an air purifying device that uses a filter medium to cleanse the contaminated air. As such, this device is limited to use in environments where sufficient oxygen is present.
 - 4. The N95/N99 respirator will not protect against radiological, chemical or nuclear hazards and only limited biological hazards. Other respirators that do provide protection against chemical inhalation are commercially available. The use of a respirator is the last resort when engineering and administrative controls cannot effectively control the exposure. The use of the respirator should be taken seriously and all employees must understand the respirator alone will not prevent exposures to contaminants. The respirator is a piece of equipment, capable of failure and must be used with diligence.

- C. Proper Selection: Respirators should be selected based on recommendations from several safety agencies such as NIOSH, American National Standards Institute (ANSI) and OSHA. Additionally, an industrial hygiene review, by a contracted vendor, of possible exposures should be conducted for a specific location/hazard if recommendations are to use a respirator with a rating higher than N95/N99 (i.e. rubber, half-face or canister style).

X. MEDICAL SURVEILLANCE

- A. Work Area: Supervisors must evaluate the work areas for hazards and compliance with this written program, all Federal and state standards. At no time is an employee to perform their duties without a respirator if the task so requires it. Furthermore, supervisors must ensure the

proper inspection, maintenance and replacement of respirators (as needed) being used by their employees. Since the contaminants are known and considered hazardous, no air monitoring will be conducted. Fieldwork where a hazard is or may be present requires a respirator be used.

- B. Medical Evaluation: All persons required by their duties to wear a respirator must be medically certified to wear the respirator. MCCCCD and SMCC use Concentra Medical Center in Arizona to perform the medical evaluation. The employee is required to complete the OSHA respiratory questionnaire and have that information reviewed by a licensed physician. Once the employee is medically cleared to use a respirator all documentation (medical questionnaire, clearance certificate, fit test procedures, etc.) must be retained by the employer for a period of employment plus 30 years.
- C. Documentation: Employees must maintain records of passing a qualitative fit test for a period of no less than one calendar year. At the end of that year the employee will be required to re-certify the mask with a new fit test. After successful passing, a new certificate will be issued for another calendar year. This process will remain in place until the employees leaves employment with MCCCCD or until the employee is no longer required to wear a respirator as part of their duties. Failure to receive a fit test certification on an annual basis will result in the employee being unqualified to perform his/her duties which require use of a respirator until such time as a fit test certification is completed.

XI. FACE FIT PROCEDURES

- A. Method: Respirators will be qualitatively fit tested using the denatonium benzoate (BITREX) method.
- B. Fitting: Employees shall be shown how to put on a respirator, how to position it on their face, how to set strap tension and determine acceptable fit. Assessment of comfort shall include a review by the wearer of the following points:
 - 1. Position of the mask on the nose.
 - 2. Room for eye protection.
 - 3. Room to speak.
 - 4. Position of the mask on the face and cheeks.
- C. Criteria: The following criteria shall be used to help determine the adequacy of the respirator fit:
 - 1. Chin is properly placed.
 - 2. Adequate strap tension (not overly tightened).
 - 3. Proper fit across bridge of nose.
 - 4. Respirator is the proper size (from nose to chin).
 - 5. Tendency of respirator to slip.
 - 6. Self-observation in a mirror.

XII. MAINTENANCE PROCEDURES

- A. **Cleaning and Disinfecting:** Employees must ensure their respirator is clean and serviceable before and after each use. The respirator should be cleaned with a warm water and mild detergent solution (without cartridges, if possible) and allowed to air dry. The respirator may be spot cleaned (prior to use only) using non-alcohol wipes. *(NOTE: This process is not applicable to N95 or N99 respirators. Discard these type respirators that are worn or non-serviceable and use a new one).*
- B. **Inspection and Maintenance:** Employees must inspect the respirator's serviceability before and after each use. The respirator must conform to the manufacturer's recommendations for proper wear and use.
- C. **Repair:** Only qualified persons may repair respirators with a rating higher than N95/N99. N95/N99 (and all paper type respirators) will be discarded and not repaired.
- D. **Storage:** Respirators must be clean prior to storage in a bag or container that is either air tight or capable of keeping contaminants and bacteria from infiltrating it. Additionally, the bag must be stored away from physical hazards or potential physical hazards.

APPENDIX A

Employer Authorization For Respiratory Evaluation

EMPLOYER AUTHORIZATION AND INFORMATION FOR RESPIRATORY EVALUATION

EMPLOYER TO COMPLETE THE FOLLOWING:

Employee Name: <u>Enter Employees Full Name</u>	Employer: <u>ENTER AGENCY</u> Dept: <u>Enter Div Or Section</u>
Employee SSN (Last 4 #'s only): <u>####</u>	Work Address: <u>Please Only Enter Employees Work Address</u>

Check Type of Respirator(s): (Check ALL that apply)

I. Air-Purifying (non-powered):

<input type="checkbox"/> 1/2 Face Make: _____ Model: _____ Canister: _____	<input type="checkbox"/> On a daily basis/Total Hours: _____
<input type="checkbox"/> Full Face Make: _____ Model: _____ Canister: _____	<input type="checkbox"/> Occasionally but not more than twice a week /Total Hours: _____
<input type="checkbox"/> Particulate Mask Make: _____ Model: _____ Type: _____ (N95, N97, N99 N100, R95, R97, R99, R100, P95, P97, P99, P100)	<input type="checkbox"/> Rarely or for Emergency situations only /Total Hours: _____

Expected Physical Effort Required (Check ALL that apply)

Light Moderate Heavy

Exposure to Hazardous Materials (Check ALL that apply)

<input type="checkbox"/> Arsenic	<input type="checkbox"/> Chromium	<input type="checkbox"/> Methylene Chloride
<input type="checkbox"/> Asbestos	<input type="checkbox"/> Coke Oven	<input type="checkbox"/> Pesticides
<input type="checkbox"/> Cotton Dust	<input type="checkbox"/> Dust/Particulates	<input type="checkbox"/> Respirable Silica
<input type="checkbox"/> Benzene	<input type="checkbox"/> Formaldehyde	<input type="checkbox"/> Solvents
<input type="checkbox"/> Cadmium	<input type="checkbox"/> Lead	<input type="checkbox"/> Welding Fumes
		<input type="checkbox"/> Wood Dust

Others(s): _____

Special Work Conditions (When Wearing Respirator)

High Places Enclosed Places Protective Clothing

Temperature Extremes Mostly Cold Mostly Hot

Other: _____

III. Atmosphere Supplying Respirator:

a. Combination Respirators

<input type="checkbox"/> Air-Line + Air-Purifying Make: _____ Model: _____ Canister: _____	<input type="checkbox"/> Others(s): _____
<input type="checkbox"/> Air-Line + SCBA Make: _____ Model: _____	

b. Self-contained Breathing Apparatus

<input type="checkbox"/> SCBA Closed Circuit Make: _____ Model: _____	
<input type="checkbox"/> SCBA Open Circuit Make: _____ Model: _____	

c. Supplied Air Respirators

<input type="checkbox"/> Air-Line Type C or CE Make: _____ Model: _____	
<input type="checkbox"/> Hose Mask Make: _____ Model: _____	

Additional Information: _____

Extent of Usage (Check ALL that apply)

DO NOT WRITE BELOW THIS LINE DO NOT WRITE BELOW THIS LINE DO NOT WRITE BELOW THIS LINE

EVALUATION AUTHORIZATION BY EMPLOYER REPRESENTATIVE:

PRINT NAME: _____

SIGN NAME: _____

Questionnaire will be: HAND CARRIED MAILED OTHER

PLHCP ¹ WRITTEN STATEMENT for RESPIRATORS (EMPLOYER)

PHYSICIAN WILL COMPLETE THE FOLLOWING

This report may contain confidential medical information and is intended for the designated employer contact only. The Americans with Disabilities Act (ADA) imposes very strict limitations on the use of information obtained during physical examination of qualified individuals with disabilities. All information must be collected and maintained on separate forms, in separate files, and must be treated as a confidential medical record, with the following exceptions:

- Supervisors and managers may be informed about necessary restrictions on the work or duties of an employee and necessary accommodations.
- First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment.

Based upon my findings, I have determined that this individual (Check ALL that apply)

Employee must schedule a medical examination with _____ prior to respirator approval and usage.

Class I – No Restrictions on Respirator Use

Class II – Some Specific Use Restrictions To be used for Emergency Response or Escape Only Other: _____

Class III – Respirator Use is NOT PERMITTED

Further Testing / Evaluation is Required.

Fit Test Required Fit Test Performed Satisfactorily

Fit Test Performed Unsatisfactorily Fit Test NOT Performed at: _____

Special prescription eyewear needed to accommodate respirator Special prescription eyewear NOT needed to accommodate respirator

Facial hair needs to be shaved to assure tight seal on certain face masks.

¹Physician or other Licensed Healthcare Professional

²Employee must seek further medical evaluation by a private physician who must submit a report of findings to _____.

(Check ALL that apply)

The above individual **HAS** been examined for respirator fitness in accordance with 29 CFR 1910.134. This limited evaluation is specific to respirator use only. Employees should be instructed to report any difficulties in using respirators or change of any physical status to their supervisor or physician. This evaluation included the Respiratory Questionnaire outlined in 29 CFR 1910.134.

The above individual **HAS NOT** been examined by me for respirator fitness. The employee's medical evaluation consisted of a review of OSHA's Medical Evaluation Questionnaire in Appendix C Part A Section 2. In accordance with 29 CFR 1910.134, this limited evaluation is specific to respirator use only. Employees would be instructed to report any difficulties in using respirators or change of any physical status to their supervisor or physician. This evaluation included the Respiratory Questionnaire outlined in 29 CFR 1910.134.

In accordance with specific OSHA requirements, I have informed the above named individual of the results of this evaluation and of any medical conditions resulting from exposures that may require further explanation or treatment. Where applicable, the above named individual has been informed of the increased risk of lung cancer attributable to the combined effect of smoking and asbestos, lead and/or other chemical exposure(s).

Physician's Signature

Physician's Name (Printed)

Physician's License Number (Optional in Most States)

Date of Exam

Expires On

APPENDIX B

Medical Evaluation Questionnaire

**U.S. PUBLIC HEALTH SERVICE
FEDERAL OCCUPATIONAL HEALTH**

**OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
Appendix C to Sec. 1910.134:**

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:

Can you read? (select one): Yes No

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 _____

Name		Job Title
Age	Male/ Female (circle one)	Height (ft, in)
A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):		Weight (lbs)
		The best time to phone you at this number:

Has your employer told you how to contact the health care professional who will review this questionnaire (select one): Yes No

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 <input type="checkbox"/> half-face <input type="checkbox"/> full-facepiece type,	<input type="checkbox"/> powered-air purifying, <input type="checkbox"/> supplied-air, <input type="checkbox"/> self-contained breathing apparatus.
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Have you worn a respirator (select 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 (please select "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?

- Seizures (fits) Yes No
Diabetes (sugar disease) Yes No
Allergic reactions that interfere with your breathing Yes No
Claustrophobia (fear of closed-in places) Yes No
Trouble smelling odors Yes No

3. Have you ever had any of the following pulmonary or lung problems?

- Asbestosis Yes No
Asthma Yes No
Chronic bronchitis: Yes No
Emphysema: Yes No
Pneumonia Yes No
Tuberculosis Yes No
Silicosis Yes No
Pneumothorax (collapsed lung) Yes No
Lung cancer Yes No
Broken ribs: Yes No
Any chest injuries or surgeries: Yes No
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?

- Shortness of breath: Yes No
Shortness of breath when walking fast on level ground or walking up a slight hill or
incline Yes No
Shortness of breath when walking with other people at an ordinary pace on level ground: Yes No
Have to stop for breath when walking at your own pace on level ground: Yes No
Shortness of breath when washing or dressing yourself: Yes No
Shortness of breath that interferes with your job: Yes No
Coughing that produces phlegm (thick sputum): Yes No
Coughing that wakes you early in the morning: Yes No
Coughing that occurs mostly when you are lying down: Yes No
Coughing up blood in the last month: Yes No
Wheezing: Yes No
Wheezing that interferes with your job: Yes No
Chest pain when you breathe deeply: Yes No
Any other symptoms that you think may be related to lung Yes No

5. Have you ever had any of the following cardiovascular or heart problems?

- Heart attack Yes No
Stroke: Yes No
Angina: Yes No
Heart failure: Yes No
Swelling in your legs or feet (not caused by walking): Yes No
Heart arrhythmia (heart beating irregularly): Yes No
High blood pressure: Yes No
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?

- Frequent pain or tightness in your chest Yes No
Pain or tightness in your chest during physical activity Yes No
Pain or tightness in your chest that interferes with your job Yes No
In the past two years, have you noticed your heart skipping or missing a beat : Yes No
Heartburn or symptoms that is not related to eating Yes No
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?

Breathing or lung problems:
Heart trouble:
Blood pressure:
Seizures (fits):

Yes No
Yes No
Yes No
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 space and go to question 9)

Eye irritation:
Skin allergies or rashes:
Anxiety:
General weakness or fatigue:
Any other problem that interferes with your use of a respirator:

Yes No
Yes No
Yes No
Yes No
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 10-15 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?

Wear contact lenses:
Wear glasses:
Color blind:
Any other eye or vision problem:

Yes No
Yes No
Yes No
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?

Difficulty hearing:
Wear a hearing aid:
Any other hearing or ear problem:

Yes No
Yes No
Yes No

14. Have you ever had a back injury:

Yes No

15. Do you currently have any of the following musculoskeletal problems?

Weakness in any of your arms, hands, legs, or feet:
Back pain:
Difficulty fully moving your arms and legs:
Pain or stiffness when you lean forward or backward at the waist:
Difficulty fully moving your head up or down:
Difficulty fully moving your head side to side:
Difficulty bending at your knees:
Difficulty squatting to the ground:
Climbing a flight of stairs or a ladder carrying more than 25 lbs:
Any other muscle or skeletal problem that interferes with using a respirator:

Yes No
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 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: _____

Have you ever worked with any of the materials, or under any of the conditions, listed below:

Substance/Conditions	Description of exposure (only if answer is yes)	
Asbestos	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Silica (e.g., in sandblasting)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tungsten/cobalt (e.g., grinding or welding this material)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Beryllium:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aluminum	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Coal (for example, mining)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Iron:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tin:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dusty environments:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any other hazardous exposures:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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)?

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) (select "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:

Light (less than 200 kcal per hour): Yes <input type="checkbox"/> No <input type="checkbox"/>	If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.
<i>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</i>	
Moderate (200 to 350 kcal per hour): Yes <input type="checkbox"/> No <input type="checkbox"/>	If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.
<i>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.</i>	
Heavy (above 350 kcal per hour): Yes <input type="checkbox"/> No <input type="checkbox"/>	If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.
<i>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.).</i>	

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 deg. 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 Toxic Substance	Estimated maximum Exposure level per shift	Duration of exposure per shift

The name of any other toxic substances that 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, security):

To the best of my knowledge, the information I have provided is true and accurate.

Employee Name

Date

Employee Signature

Employee name: _____ Age _____ Sex _____ Date of birth: _____
 Agency: _____ Work location: _____ Job title: _____
 Supervisor's name: _____ Supervisor's phone: _____ fax: _____
 Type of respirator use requested: __disposable, __negative pressure (cartridge), __PAPR, __airline, __SCBA

I. Basis for recommendations on respirator clearance:

Recommendations below on medical clearance for respirator use are based on a review of (check all that apply):

- Mandatory OSHA Respirator Medical Evaluation Questionnaire
- Records of a medical examination, including physical exam, done on: _____
- Additional information supplied by employee's personal physician.
- Other information (specify): _____

II. Recommendations on medical clearance for respirator use: (Choose A, B or C below)

A. The employee is given medical clearance to use the following respirator(s) under the conditions noted (choose all that apply)

<input type="checkbox"/> N, R or P disposable respirator (filter-mask, non-cartridge type only)	<input type="checkbox"/> Supplied air (air line) respirator
<input type="checkbox"/> Negative pressure air-purifying (cartridge) respirator -- either half- or full-face	<input type="checkbox"/> Self-contained breathing apparatus (SCBA)
<input type="checkbox"/> Powered air purifying respirator (PAPR) -- either half or full face	

When using respirators, the employee is approved to perform the following (choose one)

- Mild exertion /low heat stress
- Moderate exertion
- Heavy exertion
- Escape only
- Normal job duties
- Other Activity _____

Mild exertion (2-3 mets) e.g. lifting up to 10 lbs, extended walking on a flat surface, extended standing

Moderate exertion (4-5 mets) e.g. lifting 10 lbs, 5 lifts per min, fast walking (4 mph), gardening/digging, pushing, pulling

Heavy exertion (5-10 mets) e.g. jogging (10 min/mi), chopping wood, climbing hills, life-saving activities, fire fighting

This respirator clearance expires (circle one) 1 2 3 4 5 years from the date below (If not marked, clearance expires in 1 year)

B. The employee is not given medical clearance for respirator use because more information is needed (Specify what is needed to make a decision)

1. A medical examination, including a physical exam*, is needed to make a decision*

*- Please use the FOH Medical Surveillance Health History and Physical Evaluation forms for this

2. The following additional information is needed for review (specify what):

C. The employee is not given medical clearance for respirator use because of the health problems as noted below (choose one below)

1. A temporary health problem (which should be reevaluated in _____ months)

2. A health problem that appears permanent (routine re-evaluation is not needed)

 Examiner / Reviewer Name (Print)

 Phone number for questions

 Examiner / Reviewer Signature

 Date:

Print Health Center Stamp above