INTELLISTAFF
MEDICAL

**Respiratory Protection Fit Test**

I: OSHA Respiratory Medical Evaluation Questionnaire (attached)

- I have completed the questionnaire Part A questions 1-9

II: Respiratory Protection Education

- I have been instructed to wear a protective hood (PAPR) while providing care to any patient diagnosed or suspected of tuberculosis, until I have been fit tested with the specific type of particulate respirator at the facility where I have been assigned.

- When I am fit tested with the specific type of particulate respirator at the assigned facility, I no longer have to wear a protective hood (PAPR) when providing patient care. I am responsible for sending this documentation of the fit test to the credentialing department after the fit test has been completed.

- Respiratory face fit testing is performed annually or if I gain or lose 20 pounds or more, experience facial injury/scarring, have a change in dental structure, cosmetic surgery, grow/shave facial hair or change the type of facility specific mask that I was fit tested for.
- I have been re-educated on the need for TB respiratory protection and understand that if I have a change in any of the above – at any time – I will have to be re-fit tested immediately.
- I understand that I will be required to wear a protective hood (PAPR) until I can be re-fit tested.

III: Employee Signature: ___________________________________

Date: ____________________________

## 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. (Mandatory)**

Every employee who has been selected to use any type of respirator must provide the following information.

**Name:______________________ Title: ___________ Date: ___________________**

Age: _______ Sex: ☐ Male ☐ Female Your height: _____ ft. _____ in. Weight__________

A phone number where the health care professional who reviews this questionnaire can reach you:
Phone: ______________ 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 (Check 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 (for example, half- or full-face piece type, powered-air purifying, supplied-air, Self-contained breathing apparatus).
Have you worn a respirator (Check one): ☐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 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: ☐Yes ☐No
b) Diabetes: ☐Yes ☐No
c) Trouble smelling odors: ☐Yes ☐No
d) Claustrophobia: ☐Yes ☐No
e) Allergic reactions that affect your breathing: ☐Yes ☐No

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

a) Asbestosis: ☐Yes ☐No
b) Asthma: ☐Yes ☐No
c) Emphysema: ☐Yes ☐No
d) Pneumonia: ☐Yes ☐No
e) Tuberculosis: ☐Yes ☐No
f) Silicosis: ☐Yes ☐No
g) Pneumothorax: ☐Yes ☐No
h) Lung cancer: ☐Yes ☐No
i) Chronic bronchitis: ☐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

**Have you ever had any of the following cardiovascular or heart symptoms?**

i) Frequent pain or tightness in your chest: ☐Yes ☐No
j) Pain or tightness in your chest during physical activity: ☐Yes ☐No
k) Pain or tightness in your chest that interferes with your job: ☐Yes ☐No
l) In the past two years, have you noticed your heart skipping or missing a beat: ☐Yes ☐No
m) Heartburn or indigestion that is not related to eating: ☐Yes ☐No

**6. 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? ☐Yes ☐No**

a) Breathing or lung problems: ☐Yes ☐No
b) Heart trouble: ☐Yes ☐No
c) Blood pressure: ☐Yes ☐No
d) Seizures: ☐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) ☐ **Never used**

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 that will review this questionnaire? ☐Yes ☐No**
**If Yes, please contact the Employee Health Nurse at your assigned facility**

______________________________ ______________
Employee Signature Date