

# Medical Surveillance Respiratory Protection

Employees may be required to wear a respirator for protection against airborne exposures to various materials. In such cases, employees must be medically evaluated pursuant to Title 8 CCR, Section 5144 (e).

The medical evaluation is required before an employee is fit tested or required to use a respirator pursuant to the following:

- The medical evaluation must be performed by a physician or other licensed health care professional (PLHCP).
- The medical evaluation may be performed using a medical questionnaire (attached) or by a medical examination that obtains the same information as the questionnaire.
- Follow-up medical examinations are required when a positive response is given to any question among questions 1 through 8 in Section 2 of the questionnaire.
- The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

The PLHCP must provide a written recommendation regarding the employee's ability to use a respirator. The written recommendation must include the following information:

- Any limitations on respirator use related to the medical condition of the employee, or relating to the workplace conditions in which the respirator will be used, including whether or not the employee is medically able to use the respirator.
- The need, if any, for follow-up medical evaluations.
- A statement that the PLHCP has provided the employee with a copy of the PLHCP's written recommendation.

Additional medical evaluations shall be provided when:

- An employee reports medical signs or symptoms that are related to ability to use a respirator.
- A PLHCP, supervisor, or the respirator program administrator informs the employer that an employee needs to be reevaluated.
- Information from the respiratory protection program, including observations made during fit testing and program evaluation, indicates a need for employee reevaluation.
- A change occurs in workplace conditions (e.g., physical work effort, protective clothing, temperature) that may result in a substantial increase in the physiological burden placed on an employee.
- Re-evaluations are recommended every three years.

## Respiratory Medical Evaluation Questionnaire

**Supervisor:** Please complete Section 1 prior to distributing to the employee. Include a return envelope for employee to submit the form to the Licensed Health Care Professional (LHCP).

**Employee:** Please complete. To maintain confidentiality, please return the completed questionnaire in the envelope provided.

### Section 1 - Supervisor:

- This section **MUST** be completed prior to distributing this form to the employee.
- Please provide the employee with the name and phone number of the Occupational Physician or LHCP responsible for reviewing this questionnaire.
- To maintain confidentiality, please include a return envelope for employee to submit the form to LHCP.

Occupational Physician:

Phone No.:

1. Information on respirator to be worn by employee:

Type	Weight	Duration	Frequency of Use
<input type="checkbox"/> Negative Pressure Air Purifying	_____	_____	_____
<input type="checkbox"/> Positive Pressure Air Purifying	_____	_____	_____
<input type="checkbox"/> _____ Other	_____	_____	_____

2. Expected physical work effort:

- Light effort (i.e., walking, inspecting)
- Moderate effort (i.e., manual labor, include tool use and lifting less than 25 lbs.)
- Heavy effort (i.e., fire fighting, ladder climbing, emergency response duties, and lifting more than 25 lbs.)

3. Additional Protective Clothing and Equipment to be worn \_\_\_\_\_

4. Temperature and humidity extremes that may be encountered:

- Extreme Cold (below 30°F)
- Extreme Heat (above 100°F)
- Dryness
- Wetness
- Humidity (above 90%)
- Other \_\_\_\_\_

### Section 2 - Employee

**Per OSHA Respirator Standards, if you have been selected to wear a respirator then you MUST answer the following questions. To maintain confidentiality, please return the completed questionnaire in the envelope.**

Can you read?  Yes  No

Last Name:	Middle Initial:	First Name:	Birth Date (MM-DD-YYYY):	Male <input type="checkbox"/>	Social Security No.:
				Female <input type="checkbox"/>	

Job Title:	Work Location:
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Home Address:	City/State/Zip:	Date (MM-DD-YYYY):
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Height (ft. in.):	Weight (lbs):	Work Phone No.:	Best Time to Reach You at This No.:
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- a) Has your employer told you how to contact the health professional who will review this Questionnaire?  Yes  No
- b) Have you worn a respirator?  Yes  No
- c) Have you worn a respirator during fit testing  Yes  No
- If "Yes", what type(s) \_\_\_\_\_ (e.g., half face or full-piece, supplied air)

- |   | <u>Yes</u>               | <u>No</u>                |
|---|--------------------------|--------------------------|
| 1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?                | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had any of the following conditions:   |                          |                          |
| a) Seizures (fits)  | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Diabetes (sugar disease)   | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Allergic reactions that interfere with breathing   | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Claustrophobia (fear of closed-in places)  | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Trouble smelling odors   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had any of the following pulmonary or lung problems:                           |                          |                          |
| a) Asbestosis   | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Asthma   | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Chronic Bronchitis   | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Emphysema  | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Pneumonia  | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Tuberculosis   | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Silicosis  | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Pneumothorax (collapsed lung)  | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Lung cancer  | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Broken ribs  | <input type="checkbox"/> | <input type="checkbox"/> |
| k) Any chest injuries or surgeries  | <input type="checkbox"/> | <input type="checkbox"/> |
| l) Any other lung problem that you've been told about   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you currently have any of the following symptoms of pulmonary or lung illness:            |                          |                          |
| a) Shortness of breath  | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Shortness of breath when walking fast on level ground or walking up a slight hill or incline | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Shortness of breath when walking with other people at an ordinary pace on level ground       | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Have to stop for breath when walking at your own pace on level ground                        | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Shortness of breath when walking or dressing yourself  | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Shortness of breath that interferes with your job  | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Coughing that produces phlegm (thick sputum)   | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Coughing that wakes you early in the morning   | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Coughing that occurs mostly when you are lying down  | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Coughing up blood in the last month  | <input type="checkbox"/> | <input type="checkbox"/> |
| k) Wheezing   | <input type="checkbox"/> | <input type="checkbox"/> |
| l) Wheezing that interferes with your job   | <input type="checkbox"/> | <input type="checkbox"/> |
| m) Chest pain when you breath deeply  | <input type="checkbox"/> | <input type="checkbox"/> |
| n) Any other symptoms that you think maybe related to lung problems                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had any of the following cardiovascular or heart problems                      |                          |                          |
| a) Heart Attack   | <input type="checkbox"/> | <input type="checkbox"/> |

- |   | <u>Yes</u>               | <u>No</u>                |
|---|--------------------------|--------------------------|
| b) Stroke   | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Angina   | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Heart Failure  | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Swelling in your legs or feet (not caused by walking)  | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Heart arrhythmia (heart beating irregularly)   | <input type="checkbox"/> | <input type="checkbox"/> |
| g) High blood pressure  | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Any other heart problem you've been told about   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had any of the following cardiovascular or heart symptoms:   |                          |                          |
| a) Frequent pain or tightness in your chest   | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Pain or tightness in your chest during physical activity   | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Pain or tightness in your chest interferes with you job  | <input type="checkbox"/> | <input type="checkbox"/> |
| d) In the past two years, have you noticed your heart stopping or missing a beat  | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Heartburn or indigestion that is not related to eating   | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Any other symptoms that you think may be related to heart or circulation problems  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you currently take medication for any of the following problems:  |                          |                          |
| a) Breathing or lung problems   | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Heart trouble  | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Blood Pressure   | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Seizure (fits)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. If you have used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check the following space ___ and go to Question 9): |                          |                          |
| a) Eye irritation   | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Skin allergies or rashes   | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Anxiety  | <input type="checkbox"/> | <input type="checkbox"/> |
| d) General weakness or fatigue  | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Any other problem that interferes with your use of a respirator  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?  | <input type="checkbox"/> | <input type="checkbox"/> |

If you are selected to wear a FULL FACEPIECE RESPIRATOR or SELF CONTAINED BREATHING APPARATUS (SCBA), please answer these additional questions.

- |  | <u>Yes</u>               | <u>No</u>                |  | <u>Yes</u>               | <u>No</u>                |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 10. Have you ever lost vision in either eye (temporarily or permanently)   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 11. Do you currently have any of the following vision problems:            |                          |                          |  |                          |                          |
| a) Wear contact lenses   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| b) Wear glasses  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| c) Color blind   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| d) Any other eye or vision problems  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 12. Have you ever had an injury to your ears, including a broken ear drum? | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 13. Do you currently have any of the following hearing problems:           |                          |                          |  |                          |                          |
| a) Difficulty hearing  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| b) Wear a hearing aid  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| c) Any other hearing or ear problem  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 14. Have you ever had a back injury?                                       | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
|  |                          |                          | 15. Do you currently have any of the following musculoskeletal problems: |                          |                          |
|  |                          |                          | a) Weakness in any of your arms, hands, legs or feet                     | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | b) Back pain   | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | c) Difficulty fully moving your arms and legs                            | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | d) Pain or stiffness when you lean forward or backward at the waist      | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | e) Difficulty fully moving your head up or down                          | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | f) Difficulty fully moving your head side to side                        | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | g) Difficulty bending at your knees                                      | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | h) Difficulty squatting to the ground                                    | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | i) Climbing a flight of stairs or ladder carrying more than 25lbs        | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | j) Any other muscle or skeletal problem that interferes                  | <input type="checkbox"/> | <input type="checkbox"/> |

**Section 3 - Licensed Health Care Professional:**

- Exam Required    
 Cleared for Respirator Use    
 Not Cleared for Respirator Use    
 Personal Egress/Self Evacuation Only

Comments \_\_\_\_\_

\_\_\_\_\_

**Signature of LHCP:** \_\_\_\_\_