Health Screening Questionnaire for Respirator Users

RETURN TO (with your signature)

Department of Environmental Health and Safety
96 Albert Street, Kingston, ON K7L 2V9
Phone: 613-533-2999 Fax: 613-533-3078 Email: safety@queensu.ca

PERSONAL INFORMATION: Please Print

Name:		**Department:**	
Email:		**Building:**	
Job Title:		**Workplace/ Day Phone Number:**	
Supervisor:		**Supervisor's Phone Number:**	

List Airborne Hazards:

☐ Asbestos	☐ Dust	☐ Biohazard
☐ Silica	☐ Vapour	☐ Other _____
☐ Isocyanates	☐ Fume	

A. Types of Respirators you are required to use: (Check all applicable)

☐	**N95/ P95 – Required Use**	☐	**Self Contained Breathing Apparatus**
☐	**N95/ P95 – Personal Choice/ Comfort Use**	☐	**Half Face Respirator with Cartridges**
☐	**N100/ P100 – Required Use**	☐	**Full Face Respirator with Cartridges**
☐	**N100/ P100 – Personal Choice/ Comfort Use**	☐	**PAPR**

B. Conditions of Use: Briefly describe activities performed while wearing a respirator:

Exertion level during use	Light	☐	Moderate	☐	Heavy	☐		
Frequency of respirator use	Daily	☐	Weekly	☐	Monthly	☐	Annually	☐
Duration of respirator use in a day	< 15 min	☐	> 15 min	☐	> 2 hr	☐	Variable	☐
Temperature during use	<0'C	☐	0 – 25'C	☐	>25'C	☐	Variable	☐

C. Special Work Considerations: (Check all applicable one)
Personal Protective Equipment:

Hard Hat	☐	Tyvex Suit	☐	Confined Spaces (i.e. tanks/ man holes)	☐
Safety Glasses	☐	Emergency Escape	☐	Other (Specify):	☐

Other special work considerations (explain):

D. FOR PAPR Respirator, SCBA Respirator Users ONLY (for all other respirator types, proceed to section E)**:**

Health Conditions:
This information is required to assess any medical conditions that you may have which preclude the wearing of a **Full Face Respirator, PAPR, SCBA** respirator. Further medical examination by a physician may be required if this initial determines the need for medical clearance to wear a respirator.

Do you have any of the following conditions? ☐ **YES** ☐ **NO**

If you check **'YES'** please **DO NOT** specify your medical issues(s) on this form

Shortness of breath/ breathing difficulties	Chest pain when climbing 4 flights of steps or less	Dizziness/ fainting in hot environment
Chronic bronchitis	High Blood Pressure/ Medications	Anxiety/ Panic Attacks
Emphysema	Heart/ Cardiac Problems	Back/ neck problems
Asthma	Claustrophobia/ Fear of heights	Muscle or joint problems
Diabetes – Insulin Dependent	Fainting spells/ Seizures	

E. FOR N95, P95, N100, P100, Half Face Respirator, Full Face Respirator Users ONLY:

Health Conditions:
This information is required to assess any medical conditions that you may have which preclude the wearing of a **N95, P95, N100, P100, Half Face Respirator**. Further medical examination by a physician may be required if this initial assessment determines the need for medical clearance to wear a respirator.

Do you have any of the following conditions? ☐ **YES** ☐ **NO**

If you check **'YES'** please **DO NOT** specify your medical issues(s) on this form

Shortness of breath/ breathing difficulties	Chest pain when climbing 4 flights of steps or less	Dizziness / fainting in hot environment
Chronic bronchitis	High Blood Pressure/ Medications	Anxiety/ Panic Attacks
Emphysema	Heart/ Cardiac Problems	
Asthma	Claustrophobia/ Fear of heights	
Diabetes – Insulin Dependent	Fainting spells/ Seizures	

If I have: an allergy to Latex, wear dentures and/or have any facial skin conditions (i.e. facial acne, eczema), I will advise the fit tester at the time of my testing.

I have answered the questions to the best of my ability and knowledge. I also understand that I am to report any change in my physical health that might affect my ability to wear a respirator to my supervisor and complete a new Health Screening Questionnaire for Respirator Users.

Employee/ Student's Signature: _____ Date: _____

As the supervisor, I have reviewed all work activity hazards (including airborne hazards) with this individual. I have also advised regarding the personal protective equipment required; specifically the use of an appropriate respirator.

Supervisor's Signature: _____ Date: _____

F. Queen's Department of Environmental Health & Safety Assessment:

Referral required to Health Care Professional? ☐ YES ☐ NO

Environmental Health & Safety's Signature: _____ Date: _____

G. Health Care Professional (HCP) Primary Assessment (if required) at Walsh & Associates Occupational Health Services, Ltd.

Assessment date: _____

Medical Respirator Clearance

☐ Medically cleared for respirator use - no restrictions

☐ Medically cleared for respirator use - some specific restriction (explain):

_____

_____

☐ No respirator use permitted (explain):

_____

_____

Date	
Health Care Professional's Name	
Health Care Professional's Signature	

H. Environmental Health and Safety record of respirator fit test and respirator training.

Respirator fit test date: _____
Tester:_____ Qualitative test type: Saccharine / Bitrix
Respirator type: disposable _____ / ½ face with cartridges / full face with cartridges
Make: _____ Model:_____ Size:_____

I attest that I have been fit tested and trained on the use of the respirator listed above. I had an opportunity to ask questions and have had them answered to my satisfaction. I understand and will comply with the following (cross out if not applicable):

☐ I have read and understood SOP-Safety-05 on Respiratory Protection

☐ What type of hazard this respirator will protect me against when used properly.

☐ How to properly don this respirator, including testing for fit each time (must be clean shaven).

☐ How to properly doff this respirator and wash hands after storing or disposing the respirator as appropriate.

☐ How to clean, maintain, and store a reusable respirator (1/2 face or full face).

☐ When I should change the cartridges on a reusable respirator and how to dispose of them.

☐ How to dispose of a disposable respirator when it becomes wet, after wearing for 8 hours, or when I remove it for any reason (whichever comes first).

☐ That I should return to be retested within 2 years of this test or sooner if I experience a greater than 10% change in my body weight; a change in face shape for any reason (e.g. due to an accident or dental work); or significant acne or facial scarring that may affect the fit of this respirator.

_____ _____

Print Name of Fit tested person Signature of Fit tested person