UNIVERSITY OF ARKANSAS

RESPIRATORY PROTECTION PROGRAM
REQUEST FOR USE & MEDICAL EVALUATION QUESTIONNAIRE

PART 1. SECTION A. Mandatory. Every employee who has been selected to use any type of respirator must provide the following information.

(PLEASE PRINT)

1. Date:_____
2. Name:_____
3. Department / Office:_____
4. Job Title:_____
5. Department / Office Telephone:_____
6. Age:_____
7. Sex:_____ Male _____ Female
8. Height:_____ Feet _____ Inches
9. Weight:_____ lbs
10. Telephone number where you can be contacted by the health care professional who reviews this questionnaire:_____
11. Have you been notified regarding how to contact the health care professional who will review this questionnaire: (Circle One) Yes No
12. Type of respirator you will use (check all that apply):
    _____ N, R, or P disposable respirator (filter mask, non-cartridge type only).
    _____ Other type (half or full face type, powered air purifying, supplied air, self contained breathing apparatus [SCBA]).
13. Have you worn a respirator before? (Circle One) Yes No
14. If yes what type(s):_____

_____

Approved:_____ _____
Supervisor's Signature Date

Approved:_____ _____
Department Head Signature Date

PART 1. SECTION B. Mandatory.

Questions 1 through 9 must be answered by every person who has been selected to use any type of respirator.

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

PART 1. SECTION B. Mandatory.

Questions 1 through 9 must be answered by every person who has been selected to use any type of respirator.

	Yes	No
5. Have you ever had any of the following cardiovascular or heart problems?		
a) Heart attack		
b) Stroke		
c) Angina		
d) Heart failure		
e) Swelling in your legs or feet (not caused by walking)		
f) Heart arrhythmia (heart beating irregularly)		
g) High blood pressure		
h) Any other heart problem that you have been told about		
6. Have you ever had any of the following cardiovascular or heart symptoms?		
a) Frequent pain or tightness in you chest		
b) Pain or tightness in your chest during physical activity		
c) Pain or tightness in your chest that interferes with your job		
d) In the past two years, have you noticed your heart skipping or missing a beat?		
e) Heartburn or indigestion that is not related to eating		
f) Any other symptoms that you thing may be related to heart or circulation problems		
7. Do you currently take medication for any of the following problems?		
a) Breathing or lung problems		
b) Heart trouble		
c) Blood pressure		
d) Seizures (fits)		
8. Has your wearing a respirator caused any of the following problems?		
(If you have never used a respirator, go to question 9)		
a) Eye irritation		
b) Skin allergies or rashes		
c) Anxiety that occurs only when you use the respirator		
d) Unusual weakness or fatigue		
e) Any other problem that interferes with your use of a respirator		
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?		

PART 2.
Physician Use Only

		Pass	Fail
Blood Pressure			
Pulse			
Temperature			
Physical			

Classification for Examinee: (Physician please check the appropriate Class box here and circle classification on next page)

Class 1 **No Restriction on Respirator Use:**	
Class II **Some Specific Use Restrictions:**	
Class III **No Respirator Use Under Any Circumstances:**	

Physician's Signature _____ Date _____

PART 4. SECTION A.

FULL FACE PIECE OR
SELF CONTAINED BREATHING APPARATUS (SCBA)

These questions must be answered by persons selected to use either a full face piece 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.

Please Check "Yes" or "No"	Yes	No
1. Have you ever lost vision in either eye (temporarily or permanently)		
2. Do you currently have any of the following vision problems?		
a) Wear contact lenses		
b) Wear glasses		
c) Color blind		
d) Any other eye or vision problem		
3. Have you ever had an injury to your ears, including a broken ear drum?		
4. Do you currently have any of the following hearing problems?		
a) Difficulty hearing		
b) Wear a hearing aid		
c) Any other hearing or ear problem		
5. Have you ever had a back injury?		
6. Do you currently have any of the following musculoskeletal problems?		
a) Weakness in any of your arms, hands, legs, or feet		
b) Back pain		
c) Difficulty fully moving your arms and legs		
d) Pain or stiffness when you lean forward or backward at the waist		
e) Difficulty fully moving your head side to side		
f) Difficulty bending at your knees		
g) Difficulty squatting to the ground		
h) Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs		
i) Any other muscle or skeletal problem that interferes with using a respirator		

PART 3.
EH&S USE:

DETACH THIS PAGE AND BRING TO EH&S FOR FIT TESTING.

OFFICE OF ENVIRONMENTAL HEALTH & SAFETY
FACILITIES MANAGEMENT
521 SOUTH RAZORBACK RD
(479) 575-5448

RESPIRATOR USE CLASSIFICATION:		
Physician (circle one):		
CLASS I	CLASS II	CLASS III
Physician's Signature		Date

Employee Information:
Date:
Employee Name:
Employee ID Number:
Department:
Phone Number:

FIT TEST:		
Facial Hair:	Pass	Fail
Fit Test:	Pass	Fail

EH&S Fit Tester's Signature _____ Date _____