NOVA SOUTHEASTERN UNIVERSITY | NSU Florida

~~~~~Physician To RETURN THIS SECTION TO NSU EHS~~~~~~~

Patient Name (clearly print your name:

____

NSU Account number____________________

PHYSICIAN STATEMENT

____ No Restrictions | Cleared for Respirator ____ Specific Restrictions ____NOT CLEARED

Physician Recommendations: ____
____

Physician Signature: ____ Date ________

Return PHYSICIAN STATEMENT TO NSU EHS
Attention Beth Welmaker, Executive Director of EHS (P) 954.262.8847
Fax: 954.262.3900
Or email: ewelmaker@nova.edu

You may take to your personal physician or drop off at:

UrgentMed
2337 South University Drive
Davie, FL 33324
Phone: (954) 423-9234

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

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) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:____

2. Your name:____

3. Your age (to nearest year):____

3A. Date of Birth__________________________

4. Sex (circle one): Male/Female

5. Your height: __________ ft. __________ in.

6. Your weight: ____________ lbs.

7. Your job title:____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): ____________________

9. The best time to phone you at this number: ________________

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

11. Check the type of respirator you will use (you can check more than one category): ***Answer already provided.***

a. N95 disposable respirator (filter-mask, non-cartridge type only).

12. Have you worn a respirator (circle 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 circle "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 (sugar disease): Yes/No
    - c. Allergic reactions that interfere with your breathing: Yes/No
    - d. Claustrophobia (fear of closed-in places): Yes/No
    - e. Trouble smelling odors: Yes/No

3. Have you *ever had* any of the following pulmonary or lung problems?
    - a. Asbestosis: Yes/No
    - b. Asthma: Yes/No
    - c. Chronic bronchitis: Yes/No
    - d. Emphysema: Yes/No
    - e. Pneumonia: Yes/No
    - f. Tuberculosis: Yes/No
    - g. Silicosis: Yes/No
    - h. Pneumothorax (collapsed lung): Yes/No
    - i. Lung cancer: 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

6. Have you *ever had* any of the following cardiovascular or heart symptoms?
    a. Frequent pain or tightness in your chest: Yes/No
    b. Pain or tightness in your chest during physical activity: Yes/No
    c. Pain or tightness in your chest that interferes with your job: Yes/No
    d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No
    e. Heartburn or indigestion that is not related to eating: Yes/No
    f. 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?
    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:)
    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 who will review this questionnaire about your answers to this questionnaire: 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. 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:
____
____

2. Have you ever worked with any of the materials, or under any of the conditions, listed below:
    a. Asbestos: Yes/No
    b. Silica (*e.g.*, in sandblasting): Yes/No
    c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No
    d. Beryllium: Yes/No
    e. Aluminum: Yes/No
    f. Coal (for example, mining): Yes/No
    g. Iron: Yes/No
    h. Tin: Yes/No
    i. Dusty environments: Yes/No
    j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures:___________________________________
____
____

3. List any second jobs or side businesses you have: __________________
____

4. List your previous occupations:___________________________________
____

5. List your current and previous hobbies: ______________________________
____

6. 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

7. Have you ever worked on a HAZMAT team? Yes/No

8. 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. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

a. Emergency rescue only: Yes/No
b. Less than 5 hours *per week:* Yes/No
c. Less than 2 hours *per day:* Yes/No
d. 2 to 4 hours per day: Yes/No
e. Over 4 hours per day: Yes/No

11. During the period you are using the respirator(s), is your work effort:

a. *Light* (less than 200 kcal per hour): Yes/No
If "yes," how long does this period last during the average shift:
___________hrs.___________mins.

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.

b. *Moderate* (200 to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:___________hrs.___________mins.

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. c. *Heavy* (above 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:___________hrs.___________mins.

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.).

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12. 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:__________
____

13. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No

14. Will you be working under humid conditions: Yes/No

15. Describe the work you'll be doing while you're using your respirator(s):
____
____

16. 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):
____
____

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998; 76 FR 33607, June 8, 2011; 77 FR 46949, Aug. 7, 2012]