University of Vermont Respiratory Protection Program
OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

UVM employees who wear a respirator must complete this form annually and be medically cleared by the University's designated Physician or Licensed Health Care Professionals (PLHCP) who will perform medical evaluations using the information provided on this medical questionnaire. The completed form will be maintained in accordance with the Health Insurance Portability & Accountability Act (HIPPA), which in this case means that only designated PLHCP and clinic staff that require this information to support the employee's health & safety will see and/or maintain medical information will be the only people that have access to these records. Employees found to have risk factors that require further medical evaluation will be contacted by the designated PLHCP to schedule an appointment.

Submission Instructions: Place pages 3-7 of the completed questionnaire in a sealed envelope with your name on the outside and mail it with this page and the signed consent form (next page) in an intra-office envelope to:

Respiratory Protection Program Coordinator
Department of Risk Management & Safety
284 East Ave
Burlington, VT 05405

You must sign the next page to consent to review of your questionnaire

Date: ___________________________________

Employee Name: ____

Date of Birth: ___________________________

Job Title: ____

Campus Address: _____________________________ Email Address: _____________________________

Best Phone & Time for Healthcare Provider to reach you: ______________________________________

Supervisor Name: ____________________________ Email: ______________________________________

University of Vermont
Respiratory Protection Program

OSHA Respirator Medical Evaluation
General Consent for Review and Release of Medical Information

I certify that the statements herein are true, complete, and correct to the best of my knowledge and belief.

I consent to review of this information by Champlain Medical Urgent Care on behalf of the University of Vermont. I understand that this review is undertaken for my safety in the job environment and understand that I may be further contacted by a medical provider either for clarifications or further evaluation. Further evaluation may include, but is not limited to, a physical examination, blood tests, an evaluation of lung function, and other diagnostic tests as necessary. Costs for evaluation and testing will be covered by the University.

I further understand that the determination of whether I can safely wear a respirator will be based on the information gathered and this determination as it relates to my job and the performance of essential job functions will be released to me, my supervisor and the Respiratory Protection Program Coordinator.

Employee Signature: ____

Employee Printed Name: ____

Date Signed: ___________________________

OR

I understand that if I decline participation in the Respiratory Protection Program, my employment status might change to meet acceptable safety and wellbeing standards.

Employee Signature: ____

Employee Printed Name: ____

Date Signed: ___________________________

You will be contacted by Champlain Medical directly if applicable sections are not complete.

Champlain Medical Urgent Care Use Only:

Reviewed by:____

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):____

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):

a. ______ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

b. ______ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

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

d. 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

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece 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.

10. Have you ever lost vision in either eye (temporarily or permanently): Yes No

11. Do you currently have any of the following vision problems?

a. Wear contact lenses: Yes No

b. Wear glasses: Yes No

c. Color blind: Yes No

d. Any other eye or vision problem: Yes No

12. Have you ever had an injury to your ears, including a broken ear drum: Yes No

13. Do you currently have any of the following hearing problems?

a. Difficulty hearing: Yes No

b. Wear a hearing aid: Yes No

c. Any other hearing or ear problem: Yes No

14. Have you ever had a back injury: Yes No

15. Do you currently have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet: Yes No

b. Back pain: Yes No

c. Difficulty fully moving your arms and legs: Yes No

d. Pain or stiffness when you lean forward or backward at the waist: Yes No

e. Difficulty fully moving your head up or down: Yes No

f. Difficulty fully moving your head side to side: Yes No

g. Difficulty bending at your knees: Yes No

h. Difficulty squatting to the ground: Yes No

i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes No

j. Any other muscle or skeletal problem that interferes with using a respirator: Yes No