Health Screening Questionnaire for Respirator Users

RETURN TO (with your signature)

Department of Environmental Health and Safety
355 King Street West, 1st Floor, Suite 101, Kingston
Phone: 613-533-2999 Email: safety@queensu.ca
Forms must be submitted online before appointment www.queensu.ca/risk/safety/general/respirators

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	

Supervisors MUST complete a hazard assessment to determine the hazard exposure and the occupational exposure limit (OEL) for each contaminant. No hazard can exceed 10x the OEL.

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/ manholes)	☐
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 /Quant

Respirator type: disposable _____ / ½ face with cartridges / full face with cartridges

Make: _____ Model: _____ Size: _____

Pre-start Comfort Challenges:

- Nod head up and down
- Tilt head to touch ears to shoulders
- Turn head side to side
- Shake head vigorously, twice
- Perform facial expressions (smile, frown, open/close mouth, move jaw up/down & side to side)

Comfort Assessment (circle one):

#	Description	Corrective Action
0	No Issues	N/A
1	Discomfort that can be ignored	N/A
2	Some discomfort but still able to function	Readjust respirator
3	Unacceptable discomfort, unbearable	Rejection of respirator, try a different one

Sensitivity Test Results (total of squeezes before detection): _____

PPE compatible with respirator?	☐	YES	☐	NO
Has the respirator user shown competency during the fit test?	☐	YES	☐	NO
Fit Test Results:	☐	PASS	☐	FAIL

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 and its limitations.
- ☐ 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).
- ☐ Confirmation after fit test has been completed that this respirator provides an acceptable level of comfort for the scope of work.
- ☐ 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