Respirators must be used in workplaces in which employees are exposed to hazardous airborne contaminants. When respiratory protection is required employers must have a respirator protection program as specified in OSHA's Respiratory Protection standard (29 CFR 1910.134). Before wearing a respirator, employees must first be medically evaluated using the mandatory medical questionnaire.

Medical Evaluation and Questionnaire Requirements

The requirements of the medical evaluation and for using the questionnaire are provided below:

- The employer must identify a physician or other licensed health care professional to perform all medical evaluations using the medical questionnaire in Appendix C of the Respiratory Protection standard or a medical examination that obtains the same information. (See Paragraph (e)(2)(i).)
- The medical evaluation must obtain the information requested in Sections 1 and 2, Part A of Appendix C. The questions in Part B of Appendix C may be added at the discretion of the health care professional. (See Paragraph (e)(2)(ii).)
- The employer must ensure that a follow-up medical examination is provided for any employee who gives a positive response to any question among questions 1 through 8 in Part A Section 2, of Appendix C, or whose initial medical examination demonstrates the need for a follow-up medical examination. The employer must provide the employee with an opportunity to discuss the questionnaire and examination results with the health care professional. (See Paragraph (e)(3)(i).)
- The medical questionnaire and examinations must be administered confidentially during the employee's normal working hours or at a time and place convenient to the employee and in a manner that ensures that he or she understands its content. **The employer must not review the employee's responses, and the questionnaire must be provided directly to the health care provider by the employee.** (See Paragraph (e)(4)(i).)

Excerpt from Appendix C of 29 CFR 1910.134: OSHA Respirator Medical Evaluation Questionnaire

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.

OSHA Medical Evaluation Questionnaire

The following information must be provided by the employee who is required to use any type of respirator as part of their job-related duties.

1. Employee name:			2. Today's date:				
3. Age (nearest year):			4. Gender:		Male		Female	G-Neutral
5. Height:	Feet	Inches	6. Weight (pounds):				
7. Job Title:			8. Department:				
9. E-mail:			10. Telephone:				

11. Complete the below by requesting information from EHS on **how** to contact the health care professional **who** will review this questionnaire.

	Urgent Care (EHS Website – Approved Providers)		Student Health & Counseling (828-251-6520)
	Other provider, please specify:		

12. Best time for the reviewer to call?	Date:		AM	PM

13. Check the type of respirator you will use (you can check more than one category):

Disposable respirator (filter-mask, non-cartridge type only):		N series		R series		P series	
Other type:		Full- or half-face cartridge type		Powered-air purifying		Supplied-air	
		Self-contained breathing apparatus	*Fit testing is required, contact the EHS Professional.*				

14. Have you ever worn a respirator before?		Yes		No
If YES, what type(s):				

Questions 1 through 9 below must be answered by the employee who is required to use any type of respirator as part of their job-related duties.

1. Do you <u>currently</u> smoke tobacco, or have you smoked tobacco in the last month?		Yes		No
2. Have you <u>ever</u> 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 <u>currently</u> 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 <u>ever</u> 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 <u>ever</u> 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 <u>currently</u> take medication for any of the following problems?				
a. Breathing or lung problems		Yes		No
b. Heart trouble		Yes		No
c. Blood pressure (high or low)		Yes		No
d. Seizures		Yes		No
8. If you've <u>worn</u> a respirator, have you <u>ever</u> had any of the following problems?				
If you've <u>never</u> <u>worn</u> a respirator, check the space to the right and go to Question 9.		Never		
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		Yes		No
questionnaire, about your answers? If yes, please send the form electronically to the reviewer when completed.				

Reviewer Name:	Date of Review:
Job Title:	Institution:
Reviewer Comments (For Employee Only):	

Questions 10 to 15 below must be answered by the employee who is required to use either full-face respirator or a self-contained breathing apparatus (SCBA) as part of their job related duties. For employees, who are required to use other types of respirators, these questions are 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 eardrum?		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 ear or hearing 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 and stiffness when you lean forward or backward at the waist		Yes		No
e. Difficulty 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 pounds		Yes		No
j. Any other muscle or skeletal problem that interferes with using a respirator		Yes		No

This questionnaire does not include the questions in Part B because they are not mandatory; rather they may be added at the discretion of the health care professional if applicable. Please request the Part B form from EHS.

If the employee's answers to Part A require a more in depth medical review, where Part B would be useful, please indicate that Part B will be completed.		Yes		No

PART C – HEALTH CARE REVIEW & AUTHORIZATION OF MEDICAL EVALUATION QUESTIONNAIRE					
The following individual has been medically evaluated for the wearing of a respirator:					
Name:			NO Restriction		Restriction
This individual should not be issued respirator equipment.			CANNOT wear a respirator		
Comments:					
Licensed Healthcare Professional Authorization					
Name:		Title:			
Signature:			Date:		