Respirator Medical Evaluation

What is this?

This form is used to determine whether you are medically able to use a respirator. This is not intended to be an evaluation of your general health, but a review of the information you provide.

Why is this required?

OSHA requires that you complete a medical evaluation to qualify as medically able to wear a respirator or dust mask.

What should I do with it?

Complete the top section of page 1 and all of pages 2 through 3.

After completing the form, place it directly into a sealed envelope and mail it to:

EnviroSafe
1621 Kildeer Dr
Round Lake Beach, IL 60073

What happens next?

The form will be reviewed only by a licensed health care professional (LHCP).

If there are any questions or concerns, the LHCP will contact you to review them. A doctor's note may be required if the LHCP is unable to complete the evaluation based on the information provided.

Once you have been determined medically fit to use a respirator, an approval letter will be submitted to your shop's manager.

Who will see the information I provide on the form?

This information is confidential and it will only be reviewed by the LHCP.

Further Questions? Contact EnviroSafe at (800) 619-9733.

GMG ENVIROSAFE™

OSHA Regulations (Standards - 29 CFR)
OSHA Respirator Medical Evaluation Questionnaire
(Mandatory). – 1910.134 App C

Please return to:
EnviroSafe
1621 Kildeer Dr
Round Lake Beach, IL 60073
Fax: 847-740-1635

Medical Determination for Respirator Use

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

Date: _____
Company / Location:_____
Employee: _____
Date of Birth: _____ Male _____ Female _____
Contact Phone Number: _____ *(include area code)*
The best time to phone you at this number: _____
Your height: _____ ft. _____ in. Your weight: _____ lbs.
Job Responsibilities:
Bodyman_____ Painter _____ Detail _____Mechanic_____ Other *(please specify)*_____
Type of Respirator(s) Used:
Dust Mask _____
Air purifying cartridge, full face or half-face _____
Powered Air Purifying _____
Supplied air (airline)_____
Duration and frequency respirator required to be worn:
Daily_____ Hours/day _____
Occasionally, but more than once per week_____
Rarely, or for emergency situations only_____
Expected physical work effort while wearing a respirator:
Light (desk job)_____
Moderate (assembly line duties)_____
Heavy (construction work)_____
Strenuous (fire fighting)_____
Extremes:
Temperature _____
Humidity _____

Completed by _____Title _____ Phone: _____

Following To be completed by Licensed Health Care Professional

No restriction on use of type of respirator identified above. _____
Restricted use as stated below _____
No respirator use permitted.
Need to be checked by local health professional _____
Medical hold, awaiting more data _____

Restriction _____
_____
_____
_____

Print LHCP's Name _____
Signature: _____ Phone: _____ Date: _____

Distribution: Employer, EnviroSafe File, Employee

Please return to:
EnviroSafe
1621 Kildeer Dr
Round Lake Beach, IL 60073
Fax: 847-740-1635

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 (fits):	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

Please return to:
EnviroSafe
1621 Kildeer Dr
Round Lake Beach, IL 60073
Fax: 847-740-1635

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 (fits):	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