RESPIRATORY FIT TESTING

Urgent Orthopedics Specialists (UOS) provides - Quantitative Respirator Fit Testing only. (***Respirator Mask Fit Tests are scheduled in advance on Mondays & Wednesdays ONLY***. ***Please fill out and send back to Sharmi by email*** ssanchez@orthomidland.com ***or fax 432-699-1981 to make an appointment.)***

Employer: Please make sure to answer/complete the following:

- Employees will need to have the attached questionnaire completed ***prior*** to arrival. As per OSHA guidelines – patient answers are kept confidential and will not be shared with the employer.
  Employee Name: ______________________________ DOB: ______________ Phone#: _________________
- Respirator mask Type being used? ___________________________ Weight? ___________________________
- How long _________________________and how often _________________________will the employee be wearing the respirator?
- How hard will he/she be working and how much effort will be involved?
  ____
  ____
- Will other protective clothing or equipment be worn during respirator use? ❒Yes ❒No
- Are there temperature or humidity extremes? ❒Yes ❒No
- Have you provided a copy of the OSHA Respiratory Protection Standard and your respiratory protection program to the employee? ❒Yes ❒No

UOS has the following Respirators available for testing. Please circle type/types of respirators that the employee will need to be fitted. If your company uses a mask that is not listed, please let us know ahead of time. If the employee is already using a respirator, please send it with him/her.

DREAGER PANORAMA NOVA Full Face • R52972 (UNIVERSAL SIZE)	**SCOTT AV 3000 Full Face** • 805774-82 (Medium) • 805774-83 (Large)	**3M Half Face** • 3m6100 (Small) • 3M6200 (Medium) • 3M6300 (Large)
MSA Ultra Elite Full Face • 813208 (Medium) • 813212 (Large)	**3M Full Face** • 3M6700 (Small) • 3M6800 (Medium) • 3M6900 (LARGE) • 3M7800M (Medium) • 3M7800L (LARGE)	**N95 Mask – Please send the patient with the mask your company is currently using.**

****** UOS only provides the Fit Testing; we do not sell or dispense masks.**

Please notify your employee of the following conditions that could affect the respirator fit. Please prepare accordingly.

- Must be clean-shaven. Facial hair, mustache, facial scars may cause the mask an improper fit.
- If they wear dentures, make sure to have them in.

OSHA Fit Testing Questionnaire
Appendix C to Section 1910.134

To the Employer:

Answers to questions in Section 1, and to Section 2, question 9 of Part A, do not require a medical examination.

To the Employee:

Can you read? (check one) ❒Yes ❒No

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. All answers are CONFIDENTIAL and will not be shared with your employer.

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):

Today's Date: ______________________

Your Name: ____ Age (to nearest year): ________________

Sex: ❒ Male ❒ Female Height:________ft________in. Weight: __________

Job Title:____Phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code):_______________________________Best time to contact you at this number: __________________

Has your employer told you how to contact the health care professional who will review this questionnaire? (check one) ❒Yes ❒No

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

- ❒ N, R, or P disposable respiratory (filter-mask, non-cartridge type only).
- ❒ Other type (for example, half-or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you ever worn a respirator (check 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 check ☒ "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?

Yes	No		Yes	No	
❐	❐	-Seizures (fits)	❐	❐	-Diabetes (sugar disease)
❐	❐	-Trouble smelling odors	❐	❐	-Claustrophobia (fear of closed-in places)
❐	❐	-Allergic reactions that interfere with your breathing			

3. Have you *ever had* any of the following pulmonary or lung problems?

Yes	No		Yes	No	
❐	❐	-Asbestosis	❐	❐	-Asthma
❐	❐	-Chronic bronchitis	❐	❐	-Emphysema
❐	❐	-Pneumonia	❐	❐	-Tuberculosis
❐	❐	-Silicosis	❐	❐	-Pneumothorax (collapsed lung)
❐	❐	-Lung cancer	❐	❐	-Broken ribs
❐	❐	-Any chest injuries or surgeries	❐	❐	-Any other lung problem that you've been told about

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?

Yes	No	
❐	❐	-Shortness of breath
❐	❐	-Shortness of breath when walking fast on level ground or walking up a slight hill or incline
❐	❐	-Shortness of breath when walking with other people at an ordinary pace on level ground
❐	❐	-Have to stop for breath when walking at your own pace on level ground
❐	❐	-Shortness of breath when washing or dressing yourself
❐	❐	-Shortness of breath that interferes with your job
❐	❐	-Coughing that produces phlegm (thick sputum)
❐	❐	-Coughing that wakes you early in the morning
❐	❐	-Coughing that occurs mostly when you are lying down
❐	❐	-Coughing up blood in the last month
❐	❐	-Wheezing
❐	❐	-Wheezing that interferes with your job
❐	❐	-Chest pain when you breathe deeply
❐	❐	-Any other symptoms that you think may be related to lung problems

5. Have you *ever had* any of the following cardiovascular or heart problems?

Yes	No		Yes	No	
❒	❒	-Heart attack	❒	❒	-Stroke
❒	❒	-Angina	❒	❒	-Heart failure
❒	❒	-High blood pressure	❒	❒	-Heart arrhythmia (heart beating irregularly)
❒	❒	-Swelling in your legs or feet (not caused by walking)			
❒	❒	-Any other heart problem that you've been told about			

6. Have you *ever had* any of the following cardiovascular or heart symptoms?

Yes	No	
❒	❒	-Frequent pain or tightness in your chest
❒	❒	-Pain or tightness in your chest during physical activity
❒	❒	-Pain or tightness in your chest that interferes with your job
❒	❒	-In the past two years, have you noticed your heart skipping or missing a beat
❒	❒	-Heartburn or indigestion that is not related to eating
❒	❒	-Any other symptoms that you think may be related to heart or circulation problems

7. Do you *currently* take medication for any of the following problems?

Yes	No	
❒	❒	-Breathing or lung problems
❒	❒	-Heart trouble
❒	❒	-Blood pressure
❒	❒	-Seizures (fits)

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 box and proceed to question 9:) ❒**Never used a respirator**

Yes	No	
❒	❒	-Eye irritation
❒	❒	-Skin allergies or rashes
❒	❒	-Anxiety
❒	❒	-General weakness or fatigue
❒	❒	-Any other problem that interferes with your use of a respirator

9. Would you like to talk to the health care professional who will review 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?

Yes	No
❒	❒-Wear contact lenses
❒	❒-Wear glasses
❒	❒-Color blind
❒	❒-Any other eye or vision problem

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?

Yes	No
❒	❒- Difficulty hearing
❒	❒- Wear a hearing aid
❒	❒- Any other hearing or ear problem

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

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

Yes	No
❒	❒- Weakness in any of your arms, hands, legs, or feet
❒	❒- Back pain
❒	❒- Difficulty fully moving your arms and legs
❒	❒- Pain or stiffness when you lean forward or backward at the waist
❒	❒- Difficulty fully moving your head up or down
❒	❒- Difficulty fully moving your head side to side
❒	❒- Difficulty bending at your knees
❒	❒- Difficulty squatting to the ground
❒	❒- Climbing a flight of stairs or a ladder carrying more than 25 lbs
❒	❒- Any other muscle or skeletal problem that interferes with using a respirator

Employee Signature:____**Date:** ________________________

Reviewed by:____**Date:** ________________________