Appendix B: Respirator Medical Screening Form

First name:__________________Last:________________Middle Initial:____DOB:_______________

Employee Number: ________________Department/Unit: ____________________________________

Phone Numbers: (work) ___________________ (home) _______________ (cell) ______________

Supervisor/Manager Name & Contact Number: _________________________#__________________

Type of Respirator being fitted for: N95 Half face Full Face

PLEASE CIRCLE "YES" OR "NO" UNDER FOLLOWING TABLE AND SIGN/DATE THIS FORM. DO NOT MAKE ANY MARKS IN THE TABLE BELOW OR ADD PERSONAL MEDICAL INFORMATION.

IF YOU FEEL ANY BELOW CONDITIONS MAY AFFECT YOUR ABILITY TO SAFELY AND COMFORTABLY WEAR AND WORK WITH A RESPIRATOR, PLEASE CIRCLE "YES" AND FAX TO ORGANIZATIONAL HEALTH AT (902) 425 7229

Shortness of breath/ breathing difficulties	**Heart conditions**	**High blood pressure**
Chronic bronchitis or Emphysema	**Chest pain or pressure with activity**	**Claustrophobia**
Asthma	**Fainting or Seizures**	**Previous problem with wearing respirator**
Facial skin condition	**Anxiety/Panic attacks**	**Other**

NO YES

I understand that I should report any change in my health that might affect my ability to wear a respirator to Employee Health staff.

If I answered "Yes", I cannot be fit tested until cleared by Employee Health. An Occupational Health Nurse will contact me once for further details in order to determine if my condition will affect my ability to wear a respirator. Otherwise, it is my responsibility to contact the Occupational Health Nurse at 473-8416 to review this information.

Employee: ______________________________ Date: ____________________________