Respirator User Screening Form

There are many health concerns that do not put individuals at risk when carrying out their normal daily activities. However, the combination of a health condition when using respiratory protective equipment could put some individuals at risk. This is why it is important that you thoroughly read and carefully answer the questions on this form. If a health condition of concern is identified, you must be deemed medically fit by a health care professional before fit testing for respiratory protective equipment and performing any work requiring respiratory equipment use.

Note: If you have any concerns about your ability and medical fitness to wear respiratory protective equipment, you must request an assessment by a health care professional. If you wear prescription glasses or contact lenses, special arrangements may have to be made in order for you to wear a full face respirator.

Last Name:	Middle Initial:	First Name:	Date of Birth : *mm/dd/yyyy*

Please answer the following questions:

1. Have you ever worn respiratory protective equipment (RPE)? ☐ Yes ☐ No
   If ***yes*:
   a) Have you ever been excluded from wearing RPE or had medical restrictions? ☐ Yes ☐ No
   b) Have you ever had any problems or difficulties wearing or fitting RPE in the past? ☐ Yes ☐ No
   c) Have you ever had to remove your RPE because of difficulties during training? ☐ Yes ☐ No

2. Do you have or have you ever had any of the following problems or medical conditions:
   - Epilepsy ☐ Yes ☐ No
   - Diabetes or metabolism problem ☐ Yes ☐ No
   - Allergic reactions that interfere with your breathing ☐ Yes ☐ No
   - Claustrophobia/Anxiety/panic attacks ☐ Yes ☐ No
   - Fainting/dizziness/stroke ☐ Yes ☐ No

3. Do you have or ever had any of the following pulmonary or lung problems:
   - Asthma /Shortness of breath/wheezing ☐Yes ☐ No
   - Chronic Bronchitis/emphysema/tuberculosis ☐ Yes ☐ No
   - Coughing blood/ Lung cancer/asbestosis/silicosis ☐ Yes ☐ No
   - Any other lung problems for which you are aware of ☐ Yes ☐ No

4. Do you have or ever had any of the following cardiovascular or heart symptoms or problems:
   - Heart attack/stroke/heart failure ☐ Yes ☐ No
   - Chest pain or tightness/ angina ☐ Yes ☐ No
   - High blood pressure ☐ Yes ☐ No
   - Any other heart conditions for which you are aware of ☐ Yes ☐ No

5. Do you have any concerns about your medical fitness when it comes to wearing a respirator? ☐ Yes ☐ No

6. Do you wear prescription glasses or contact lenses? ☐ Yes ☐ No

Important: I understand that if I have answered "Yes" to questions 2 through 5 on this form it will be requested that you seek clearance from a medical professional to wear Respiratory Protective Equipment.

By signing below, I ***confirm*** that my answers to the above questions are accurate to the best of my knowledge and I consent to the above.

Signature	*Date*