

## Department of Occupational Health

### Onboarding Medical Exam Packet

**ST Francis Hospital & Medical Center**

ST Francis Occupational Health  
114 Woodland Street, Suite 4320  
Gengras Office Building  
Hartford, CT 06105 - (860) 714-4270

**Exam Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**ST Mary's Hospital**

ST Mary's Occupational Health  
1312 W Main St, Waterbury, CT 06708 - (203) 709-3740

**Exam Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Mercy Medical Center**

Workwise Occupational Health & Industrial Rehab At Mercy Hospital  
300 Stafford Street, Suite 256 Springfield, MA 01104 · (413) 748-6869

**Exam Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Johnson Memorial Hospital**

Johnson Occupational Medicine  
155 Hazard Ave # 6, Enfield, CT 06082 - (860) 763-7668

**Exam Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

***All NEW Trinity Hires are required to bring immunization documentation listed below regardless of where they work within Trinity Health of New England. If any employee is not able to obtain any of the immunization information LISTED BELOW all appropriate titers or vaccines will be given at Occupational Health appointment.***

- Proof of 2 MMR's or Positive Titers (Rubella, Mumps, Rubeola)
- Proof of 2 Varicella's or Positive Titers.
- Proof of Flu Vaccine (only during Flu season)
- Proof of TDAP (Clinical positions only or Child Development Center employees)
- Hepatitis B series or Positive titer (For clinical positions only)
- *Mercy Medical Center Only- Proof of 2 step PPD within one month of hire.*
- All Male employees MUST shave before appointment to be compliant with OSHA for FIT testing requirements.

***Bring this packet completely filled out with you at time of appointment.  
For questions or concerns please call the Occupational Health facility where  
Your exam is scheduled.***

## Department of Occupational Health

### Consent and HIPAA Acknowledgement Form

I consent to the use or disclosure of my protected health information the Center for Occupational Health, and affiliate of Trinity Health of New England to any person or organization, for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by Trinity Health of New England, or its affiliates may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how Saint Mary's or its affiliates will use and disclose my information can be found in the Saint Mary's Notice of Privacy Practices. I understand that this consent is effective for as long as Saint Mary's or its affiliates maintain my protected health information.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent; and
- I have received the THOFNE of Privacy Practices currently in effect.

\_\_\_\_\_  
Print Name of individual or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of individual or Personal Representative

\_\_\_\_\_  
Date

#### Office Use Only

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual: \_\_\_\_\_

#### Office Staff

I made a good faith effort to obtain a written acknowledgement of receipt of Notice of Privacy Practices from the above-named patient, but was unable to because:

- Individual refused
- Emergency treatment situation
- Individual not able to sign due to incompetence or other medical reason
- Other: \_\_\_\_\_



**Department of Occupational Health**

**Consent an Acknowledgment Form Contact Information**

The Medical Review Officer may need to contact you for more information to properly interpret your drug test result.

<b>Last Name:</b>	<b>First Name:</b>
<b>Date of Birth:</b>	<b>Social Security Number:</b>
<b>Street Address:</b>	<b>City:</b>
<b>State:</b>	<b>Zip Code:</b>
<b>Home Phone:</b>	<b>Cell Phone:</b>
<b>Email:</b>	<b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> non-Hispanic <input type="checkbox"/> Decline to specify
<b>Company Name:</b>	<b>Primary Language:</b> _____
<b>Position:</b>	<b>Race:</b> <input type="checkbox"/> Caucasian/ White <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown
<b>Work Phone:</b>	<input type="checkbox"/> Decline

**Consent for Urine Drug Testing**

I hereby give my voluntary consent for a urine sample to be collected from me and submitted for drug testing. I understand that the specimen will be collected using a chain of custody procedure and will be sent to a SAMSHA – approved laboratory for testing if deemed non-negative. The laboratory results will be reviewed by a Medical Review Officer who may contact me to discuss my personal physicians to verify medical or prescription information.

I understand that the Medical Review Officer will make a final determination of the test result and will notify Human resources of this result. If my urine is determined “positive”, I understand that I have 72 hours to request a re-analysis of the same specimen or a split specimen according to company policy.

I have read the Urine Drug Screening Procedure Information Sheet and this Consent Form. Any questions that I had regarding this procedure have been answered to my satisfaction.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



**Department of Occupational Health**

**OCCUPATIONAL HEALTH WORK, ENVIRONMENT AND HEALTH QUESTIONNAIRE**

Last Name:		First Name:	
Date of Birth:		Social Security Number:	
Street Address:		City:	
State:		Zip Code:	
Home Phone:		Cell Phone:	
Email:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> non-Hispanic <input type="checkbox"/> Decline to specify	
Company Name:		Primary Language: _____	
Position:		Race: <input type="checkbox"/> Caucasian/ White <input type="checkbox"/> African American <input type="checkbox"/> Asian	
Work Phone:		<input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown	
		<input type="checkbox"/> Decline	

**OCCUPATIONAL HISTORY**

List every place where you have been employed for **more than six (6) months** back to your first job, starting with your current or most recent job.

Start Mo/ Yr	End Mo/ Yr	Employer, City State	Type of Business	Job Title	Job Duties	Exposures

Have you ever worn a respirator at work? Yes \_\_\_\_\_ No \_\_\_\_\_

Were you able to perform your job with a respirator on? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you wear contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_

Hobbies: \_\_\_\_\_

**IMMUNIZATION HISTORY**

Please provide a written record signed by your physician with dates for the following vaccinations, or titers. If you cannot provide these, you will be tested for immunity to these diseases.

- A. Proof of 2 MMR's or Positive Titers Rubella and Rubeola
- B. Proof of 2 Varicella's or Positive Titers
- C. Proof of TDAP
- D. Mercy Hospital only – Proof of 2 step PPD within one month of hire
- E. Hepatitis B series or Positive Titer



**Department of Occupational Health**

**SMOKING AND ALCOHOL USE**

Have you ever smoked cigarettes regularly? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, do you still smoke? Yes \_\_\_\_\_ No \_\_\_\_\_

When did you quit smoking? (Date) \_\_\_\_\_

How many years have you smoked, or if you no longer smoke, how many years did you smoke? \_\_\_\_\_ yrs.

On the average, how many packs per day do you smoke, or if you no longer smoke, how many did you smoke?  
\_\_\_\_\_ packs per day.

Have you ever smoked a pipe or cigars regularly? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever been a regular consumer of beer or other alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_

**FAMILY PHYSICIAN**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date last seen by a physician: \_\_\_\_\_

Are any other physicians currently treating you? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please write their name, address and telephone number:

\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY**

Current Medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Allergies to medications and other substances: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been in the hospital? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when, where, and why? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Department of Occupational Health**

**MEDICAL HISTORY CONTINUED**

Do you have or have you ever had any of the following:

	YES	NO	Date of Onset	If yes, Please Detail
Have you received COVID Vaccine				
Arthritis, Rheumatic Fever				
Liver Disease, including Hepatitis				
Skin Condition				
Miscarriage (Self or Partner)				
Infertility, Child with Birth defect				
Tuberculosis				
Ulcers, Other Stomach or Bowel Disease				
Gallbladder Disease				
Disorder of Bones or Muscles				
Fractures				
Thyroid Problems				
Diabetes				
Kidney Disease				
Problems with Peripheral Nervous System (Weakness/ Seizures)				
Rupture of Eardrum, Hearing Loss				
Cancer or Tumor (type)				
Epilepsy (Seizures)				
Back Injury, Pain or Trouble				
Lung Conditions (Bronchitis, Emphysema, Pneumonia, Asthma, Blood clot in lungs)				
Injuries to other Body Parts				
Heart Disease, Including Hypertension				
Other Condition				
Date of Last Eye Exam				

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Provider: \_\_\_\_\_ Date: \_\_\_\_\_



Trinity Health  
Of New England

OSHA Blood Borne Pathogens Regulation

Hepatitis B Vaccine

**Declination**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me; however, I **decline** hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Vaccinating** I understand that due to my occupational exposure to blood and other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the hepatitis B vaccine at no charge to myself and **wish to begin series today.**

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Previously Vaccinated** I declare that I have **previously received** the Hepatitis B vaccination series and therefore decline to participate. **Attached is a copy of my immunization and or titer history showing proof of vaccination.**

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_





**Department of Occupational Health**

**Tdap (Tetanus, Diphtheria, Pertussis) Vaccine**

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Declination:** I have been given the opportunity to be vaccinated with **Tetanus, Diphtheria and Pertussis (Tdap Vaccine)**, at no charge to me; however, I decline vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring three infectious diseases in humans: Diphtheria, pertussis, and tetanus. If, in the future I continue to have occupational exposure and I want to be vaccinated with, **Tdap** I can receive the vaccination to no charge to me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Vaccinating:** I request the vaccine be given to me

Please answer the following questions	YES	NO
Are you pregnant? (Women of childbearing age)		
Are you allergic to latex?		
Do you currently have a fever or illness?		
Have you ever had an allergic reaction to tetanus, diphtheria and/or pertussis vaccine?		
Do you have or have you ever had a central nervous system disorder? (Seizures, MS, GBS, etc....)		
Have you ever fainted or almost fainted following a vaccination or blood draw?		

I have read the vaccination information statement sheet about **Tdap (Tetanus, Diphtheria and Pertussis) Vaccine**. I have had the opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of the Tdap vaccination. I understand that, as a result of receiving this vaccination, there is no guarantee that I will achieve immunity or that I will not experience adverse side effects from the vaccine.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical Staff only**

Documentation of Immunization:

Manufacturer: \_\_\_\_\_ Lot #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

0.5 ML IM administered to the LEFT/RIGHT deltoid by \_\_\_\_\_ Date: \_\_\_\_\_

Medical Staff





**OH Tuberculosis Risk Assessment, Signs & Symptoms Questionnaire**

Employee Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**\*\*\*\*Risk Assessment\*\*\*\***

Healthcare employee should be considered at increased risk for TB if any of the following are marked yes.

Temporary or permanent residence of ≥1 month in a country with a high TB rate. (Any country other than the United States, Canada, Australia, New Zealand, & those in Northern Europe or Western Europe).

YES  NO

Current or planned immunosuppression, including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month) or other immunosuppressive medication.

YES  NO

Close contact with someone who has had infectious TB disease since the last TB test.

YES  NO

**\*\*\*\*TB Signs and Symptoms Screening Questionnaire\*\*\*\***

Are you currently experiencing ANY of the following symptoms?

- Persistent cough of > 2 weeks duration YES  NO
- Bloody sputum YES  NO
- Night sweats YES  NO
- Weight loss YES  NO
- Anorexia YES  NO
- Fever YES  NO

Test performed - the QuantiFERON-TB Gold test, also known as a TB blood test, is a blood test that checks for prior exposure to Tuberculosis.

Result: Positive: \_\_\_\_\_ Negative: \_\_\_\_\_ Date: \_\_\_\_\_

PPD planted Date \_\_\_\_\_ Time \_\_\_\_\_ R arm \_\_\_\_\_ L arm \_\_\_\_\_ Provider \_\_\_\_\_

Lot number \_\_\_\_\_ Expiration date \_\_\_\_\_

Date Read \_\_\_\_\_ Result \_\_\_\_\_ Provider \_\_\_\_\_

→ Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## OSHA Respirator Medical Evaluation Questionnaire

*This evaluation questionnaire is required by the US Department of Labor for any health care professional who may need to use any type of respirator at work.*

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.

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).

1. Today's date: \_\_\_\_\_

2. Your name: \_\_\_\_\_

3. Your age (to nearest year): \_\_\_\_\_

4. Sex (circle one): Male/Female

5. Your height: \_\_\_\_\_ ft. \_\_\_\_\_ in.

6. Your weight: \_\_\_\_\_ lbs.

7. Your job title: \_\_\_\_\_

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): \_\_\_\_\_

9. The best time to phone you at this number: \_\_\_\_\_

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

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

a. \_\_\_\_\_ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

b. \_\_\_\_\_ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle 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 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: **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**
  - 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**
- d. 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: **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**

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?

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 ear drum: **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 hearing or ear 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 or stiffness when you lean forward or backward at the waist: **Yes/No**

e. Difficulty fully 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 lbs: **Yes/No**

j. Any other muscle or skeletal problem that interferes with using a respirator: **Yes/No**

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than



normal amounts of oxygen: **Yes/No**

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: **Yes/No**

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: **Yes/No**

If "yes," name the chemicals if you know them: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos: **Yes/No**

b. Silica (e.g., in sandblasting): **Yes/No**

c. Tungsten/cobalt (e.g., grinding or welding this material): **Yes/No**

d. Beryllium: **Yes/No**

e. Aluminum: **Yes/No**

f. Coal (for example, mining): **Yes/No**

g. Iron: **Yes/No**

h. Tin: **Yes/No**

i. Dusty environments: **Yes/No**

j. Any other hazardous exposures: **Yes/No**

If "yes," describe these exposures: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. List any second jobs or side businesses you have: \_\_\_\_\_

\_\_\_\_\_

5. List your previous occupations: \_\_\_\_\_

\_\_\_\_\_

6. List your current and previous hobbies: \_\_\_\_\_

\_\_\_\_\_

7. Have you been in the military services? **Yes/No**

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you ever worked on a HAZMAT team? **Yes/No**

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes/No

If "yes," name the medications if you know them: \_\_\_\_\_

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters: **Yes/No**

b. Canisters (for example, gas masks): **Yes/No**

c. Cartridges: **Yes/No**

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

a. Escape only (no rescue): **Yes/No**

b. Emergency rescue only: **Yes/No**

c. Less than 5 hours *per week*: **Yes/No**

d. Less than 2 hours *per day*: **Yes/No**

e. 2 to 4 hours per day: **Yes/No**

f. Over 4 hours per day: **Yes/No**

12. During the period you are using the respirator(s), is your work effort:

a. *Light* (less than 200 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.

b. *Moderate* (200 to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or *pushing* a wheelbarrow with a heavy load (about 100 lbs.) on a level surface. c. *Heavy* (above 350 kcal per hour):  
Yes/No

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; *shoveling*; *standing* while bricklaying or chipping castings; *walking* up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No

If "yes," describe this protective clothing and/or equipment: \_\_\_\_\_  
\_\_\_\_\_

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No

15. Will you be working under humid conditions: Yes/No

16. Describe the work you'll be doing while you're using your respirator(s):  
\_\_\_\_\_  
\_\_\_\_\_

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):  
\_\_\_\_\_  
\_\_\_\_\_

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

Name of the second toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

Name of the third toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

The name of any other toxic substances that you'll be exposed to while using your respirator:  
\_\_\_\_\_  
\_\_\_\_\_



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19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security:

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[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998; 76 FR 33607, June 8, 2011; 77 FR 46949, Aug. 7, 2012]