New Employee Occupational Health Packet

The enclosed packet was designed to expedite your Urine Drug Screen and Pre-employment Physical appointment in Occupational Health. The packet contains:

1. Immunization Requirements
2. Registration Information
3. Drug Screen Procedure
4. Urine Drug Screen Consent
5. Medical & Occupational History Questionnaire
6. Tuberculosis Screening Form
7. OSHA Respirator Medical Evaluation Questionnaire (for Fit testing, where applicable)

BEFORE the day of your Occupational Health appointment:

1. Complete all of the forms in this packet
2. Obtain all of your vaccination records and/or proof of immunity

ON THE DAY of your Occupational Health appointment:

1. Plan to arrive at least 15 minutes before your scheduled appointment. Late arrivals may have to be rescheduled. Directions are included on the last page of this packet.
2. Bring the completed forms / this packet with you
3. Bring all of your vaccination records and/or proof of immunity if they are available
4. Bring a valid photo ID (driver’s license, passport, military ID, or school ID)

*** IMPORTANT ***

YOU WILL NOT be cleared (approved) to attend orientation and begin your employment unless all of the requirements are completed and documents received.

If for any reason you need to reschedule your appointment please call Occupational Health at (P) 203-709-3740.
IMMUNIZATION REQUIREMENTS

The following is a check list of the immunizations that are a requirement of employment with Saint Mary’s Hospital / Trinity Health Of New England.

Please bring your immunization records with you to your appointment. If you do not have immunization records or fail to bring them to your appointment, your clearance may be delayed pending blood work results.

MANDATORY:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Proof of 2 MMR (measles, mumps, &amp; rubella) vaccines or positive titers.</td>
<td><strong>NOTE</strong>: not required if born before 1956.</td>
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<tr>
<td>Proof of 2 Varicella (chickenpox) vaccines or positive titer/history of</td>
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<tr>
<td>disease.</td>
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<tr>
<td>Proof of Tuberculin skin test (PPD) or Quantiferon Gold blood test</td>
<td><strong>NOTE</strong>: if you have had a positive PPD in the past please bring most recent Chest x-ray</td>
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<tr>
<td>Proof of current seasonal influenza (flu) vaccination (mandatory during flu</td>
<td><strong>NOTE</strong>: seasonal flu vaccination is an annual requirement of employment.</td>
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<tr>
<td>season.</td>
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<td>Proof of 2 Hepatitis A vaccines (mandatory for Child Development Center</td>
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<tr>
<td>and Food &amp; Nutrition Services employees only)</td>
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<tr>
<td>Proof of Tdap (tetanus, diphtheria, and pertussis); mandatory for Child</td>
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<td>Development Center and Women &amp; Infants Center employees.</td>
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OPTIONAL:

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<tr>
<th>Requirement</th>
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<tbody>
<tr>
<td>Proof of 3 Hepatitis B vaccines or Positive titer</td>
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<tr>
<td>Proof of Proof of Hepatitis C antibody</td>
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<td>Proof of Proof of recent CBC (complete blood count)</td>
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# OCCUPATIONAL HEALTH & DIAGNOSTIC CENTER

## REGISTRATION INFORMATION

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<tr>
<th>Age</th>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>Social Security #</th>
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**Home Address**

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<th>City</th>
<th>State</th>
<th>Zip code</th>
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<th>Home Phone</th>
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**Gender:**

- Male
- Female

**Race:**

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<tr>
<th>Marital Status:</th>
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**Do you smoke?**

- Yes
- No

**Employer Name:**

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<tr>
<th>Occupation:</th>
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Saint Mary’s Occupational Health Center - 1312 West Main Street, Waterbury, CT 06708
Saint Mary’s Hospital Urine Drug Screening Procedure

You have been asked by your employer or by your prospective employer to provide a urine specimen for drug testing. We would like to explain our procedure to you.

When you come to our Center, you will be asked to show a photo identification to the health care professional who collects your specimen. That person will be wearing their Saint Mary’s Hospital photo identification badge. Your driver’s license is the best form of identification. A military ID, passport, or school photo ID is also acceptable. **Expired ID documents cannot be used.**

Your urine specimen will be collected according to procedures described by the National Institute on Drug Abuse (NIDA) and sent to a NIDA-approved laboratory for analysis.

You will be asked to remove your outer garments and leave them along with any personal belongings outside the bathroom. Valuables such as your wallet or pocketbook will be locked in a cabinet (lockbox) inside the bathroom.

You will be given a container in which to urinate. You will wash and dry your hands in the collector’s presence both before and after producing the urine specimen. After washing your hands, the collector will turn off the water in the sink. You will then urinate in the privacy of a locked bathroom without observation. You will be told not to flush the toilet after you void.

You must produce at least 45-60 cc of urine in the container that we give you. If you feel that you cannot produce this amount of urine, tell the collector. If you do produce a specimen that is less than one ounce, it will be discarded. You will have up to 3 hours to produce a sufficient new specimen. You will be provided with up to 40 ounces of fluid to drink. During this time, you must remain at the Center.

Within four minutes after you produce the urine specimen, the collector will measure the urine temperature. If the temperature is outside the acceptable range, the collector will take your temperature orally. The collector will inspect the specimen for color, appearance, and signs of contamination.

You and the collector will complete the process together by sealing and labeling the specimen bottle. You will initial the label and sign and date the custody form.

The urine specimen will be sent to a NIDA-approved laboratory for analysis. The urine will undergo a 7-panel drug screening.

All test results will be reviewed by a physician, who is certified as a Medical Review Officer, to evaluate drug test results. If the laboratory indicates that the specimen tests positive for one of the seven drugs screened form the Medical Review Officer will call you to discuss the test results.

**Only one of the following results will be reported to the Saint Mary’s Human Resource Representative: Positive, Negative or Test Not Performed.**

We will be happy to answer any questions you may have. Thank you for your cooperation.
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 NIDA-approved laboratory for testing. The laboratory results will be reviewed by a Medical Review Officer who may contact me to discuss the results and to obtain further information. I give permission to the Medical Review Officer to contact 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 notify Human Resources of this result. If my urine is determined to be “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 at my own cost.

I have read the Urine 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 Signature: __________________________ Date: __________________________

Contact Information

Please provide the following information in the event the Medical Review Officer needs to contact you for more information to properly interpret your drug screen result.

Last Name: __________________________ First Name: __________________________
Social Security #: __________________________
Address: ______________________________________________________________
Phone number where you can be reached on weekdays between 8am-4pm: __________________________
PATIENT MEDICAL & OCCUPATIONAL HISTORY QUESTIONNAIRE

Last Name: ____________________________  First Name: ____________________________

Date of Birth: ____________________________

<table>
<thead>
<tr>
<th>Do you have, or have you ever had:</th>
<th>No</th>
<th>Yes</th>
<th>If Yes, explain</th>
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<tr>
<td>Any vision problems?</td>
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<td>Wear corrective lenses – Reading?</td>
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<td>Wear corrective lenses - Distance?</td>
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<td>Wear corrective lenses – Contacts?</td>
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<td>Any hearing problems?</td>
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<td>Wear hearing aid(s)?</td>
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<td>Ruptured ear drum?</td>
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<td>Claustrophobia</td>
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<td>Carpal Tunnel Syndrome (CTS)</td>
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<td>R or L?</td>
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<td>Surgery to repair carpal tunnel syndrome?</td>
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<td>Hernia?</td>
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<td>Type?</td>
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<td>Surgery to repair hernia?</td>
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<td>Back injury?</td>
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<td>Circle all that apply: neck / mid-low back</td>
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<td>Surgery for back injury (type &amp; date)?</td>
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<td>Joint injury / pain (list joints)?</td>
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<td>Arthritis (list joints)?</td>
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<td>Broken bones (list which bones)?</td>
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<td>Asthma?</td>
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<td>Latex allergy?</td>
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<td>Allergies to prescription or over the counter medications?</td>
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<td>Other allergies (list type)?</td>
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<td>History of Tuberculosis (if yes indicate treatment received &amp; date)?</td>
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<td>Persistent cough (with or without blood)?</td>
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<td>Other surgeries (list type and date)?</td>
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OCCUPATIONAL HISTORY (please circle Yes or No):

Have you ever been exposed to any known occupational hazard such as: noise, radiation, dust, asbestos, chemicals and lead? Yes or No
If yes, please specify: ____________________________________________

Have you ever used protective clothing, safety glasses or hearing protection? Yes or No
If yes, please specify: ____________________________________________

Have you ever worn a respirator? Yes or No
If yes, please specify: ____________________________________________

Have you ever developed a medical condition in connection with your occupation?
If yes, please specify: ____________________________________________
Have you ever suffered from any workplace injury? Yes or No
If yes, please specify: ____________________________________________________________

Have you ever had any previous hearing tests? Yes or No
If yes, are you able to supply a copy or the results: Yes or No
If yes, was the results normal: Yes or No

Do you have any disabilities? Yes or No
If yes, please specify: __________________________________________________________

Can you perform the essential functions of the job you are applying for with or without reasonable accommodations? Yes or No

Have you ever been rejected from employment or insurance coverage based on medical grounds? Yes or No
If yes, please specify: __________________________________________________________

Have you ever received compensation for a workers compensation claim or do you have any workers compensation claims pending? Yes or No
If yes, explain: ___________________________________________________________________

Do you use any durable medical equipment or devices (e.g., braces, crutches, artificial limbs) Yes or No
If yes, please explain: __________________________________________________________________

Do you have any hobbies? Yes or No
If yes, please list hobbies, substances used (e.g., glue, paint, chemicals) and physical exposure (e.g., noise, temperature extremes): ______________________________________________

Have you ever had a chest x-ray? Yes or No
If yes, date of most recent: ______________
If yes, are you able to provide a copy of the result? Yes or No

Medications: Since a urine drug screening is required as part of Saint Mary’s Hospital / Trinity Health Of New England pre-employment process, please list all medications you are currently taking, both prescribed and over the counter:
____________________________________________________________________________
____________________________________________________________________________

______ Applicants/Employee: I certify that the above information is true and correct to the best of my knowledge.

_________________________________________       ________________________________
Patient Signature                           Date

_________________________________________       ________________________________
Provider Signature                          Date
Tuberculosis Screening Form

<table>
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<tr>
<th>Last Name</th>
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Social Security # __________________________ Phone (where can be reached M-F, 8:00 am – 4:30 pm)

Name of Company: ____________________________________________ Date: ____________

**Please answer the following questions:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Are you Taking Immunosuppressive medication or steroids for any medical problem (e.g., Colitis, Rheumatoid Arthritis, Psoriatic Arthritis or Lupus)?</td>
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<td>Have you experienced considerable weight loss (not diet related)?</td>
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<tr>
<td>Do you have night sweats (not hormone related)?</td>
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<tr>
<td>Have you had a Positive tuberculin skin test in the past? *</td>
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<tr>
<td>Have you received preventative treatment for a positive PPD? *</td>
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<tr>
<td>Have you ever had a BCG Vaccine (only given outside of the U.S.)?</td>
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<tr>
<td>Have you been diagnosed with tuberculosis in the past?</td>
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<tr>
<td>Do you have a productive cough?</td>
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<tr>
<td>What is the date of you last Chest X-Ray? Date: ____________</td>
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**Office Use Only**

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<tr>
<th>Annual: ______</th>
<th>Baseline: _____</th>
<th>Post Exposure: _____</th>
<th>Q3months: _____</th>
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</table>

The above individual received a PPD test on: ________________

Lot #: __________ Exp Date: __________ Manufacturer: S Pasteur, Dose: 0.1ml ID

Test Placed: RA____ LA_____ Other ____ Placed by: ____________________________

The result was: Negative: _____ Positive: ____ MM induration: _____ Not read in 72hrs: ______

Date Read: __________ Authorized signature: ____________________________

* Please fax a copy of all readings to SMH Occ. Health at 203-709-3741

* If positive: Referred to Franklin Medical Group, Dr. Beri and Dr. Zhang’s office, TB clinic held on Tuesdays @ 133 Scovill Street, Suite 308 Waterbury, CT (P) 203-709-6244.

With my signature below I acknowledge that I received medical information regarding my positive PPD.

Patient Signature __________________________ Date ____________

56 Franklin Street • Waterbury, CT 06706 • 203-709-6000 • stmh.org
DIRECTIONS TO SAINT MARY’S HOSPITAL OCCUPATIONAL HEALTH CENTER

1312 West Main Street, Waterbury, CT 06708

(P) 203-709-3740

From the East (Cheshire, Southington, Hartford, etc.)
- Take I-84 to Exit 18 – Highland Avenue- toward West Main Street (bear Left on exit ramp)
- At the end of the Exit ramp turn left at the light and a quick right into the parking lot.

From the West (Middlebury, Southbury, Danbury, etc.)
- Take I-84 to exit 18 – Chase Parkway
- At end of ramp/intersection turn Right onto Chase Parkway
- Turn Right at traffic light still following Chase Parkway, crossing over I-84
- At next traffic light turn Right onto West Main Street
- The SMH Occupational Health Center is located on the Left side of West Main Street (across from CVS Pharmacy)

From the South (Naugatuck, Bridgeport, Beacon Falls, etc.)
- Take Rte. 8 North to the I-84 West Exit (toward Danbury) Left Exit
- Take the 1st Exit (Exit 18) on the Right
- Bear Left to the light and take a Left at the light
- Take 1st Right into parking lot

From the North (Watertown, Torrington, etc.)
- Take Rte. 8 South to I-84 West (towards Danbury)
- Take 1st Exit (Exit 18)
- Bear Left on the Exit ramp towards West Main Street
- At the end of the Exit ramp turn left at the light and a quick right into the parking lot
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:

_______________________________________________________________________

_______________________________________________________________________
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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