Trinity Health
Of New England
**Department of Occupational Health**

# Onboarding Medical Exam Packet

## St. Francis Hospital & Medical Center

Exam Date: _____ Time: _____

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

## St. Mary's Hospital

Exam Date: _____ Time: _____

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

## Mercy Medical Center

Exam Date: _____ Time: _____

Mercy Occupational Health
299 Carew Street, Suite #323
Springfield, MA 01104 · (413) 748-6870

## Johnson Memorial Hospital

Exam Date: _____ Time: _____

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

***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 above immunization information all appropriate titers or vaccines will be given at Occupational Health appointment.*

- Proof of 2 MMR's or Positive Titers (Measles, Mumps, Rubella)
- Proof of 2 Varicellas 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)
- 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.***

Trinity Health
Of New England

## 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 ma 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: _____

Trinity Health
Of New England

## 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.

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

Trinity Health
Of New England

## 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:** ☐ Hispanic ☐ non-Hispanic ☐ Decline to specify |
| **Company Name:**<br>**Position:**<br>**Work Phone:** | **Primary Language:** _____<br>**Race:** ☐ Caucasian/ White ☐ African American ☐ Asian ☐ Native American ☐ Hispanic ☐ Unknown ☐ 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

Trinity Health
Of New England

## 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? _____

_____

Trinity Health
Of New England

## 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: _____

Trinity Health
Of New England

## 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

Trinity Health
Of New England

# 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:** _____

Trinity Health
Of New England

# 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:

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