# Health Screening Questionnaire for Respirator Users

**RETURN TO (with your signature)**

Department of Environmental Health and Safety  
96 Albert Street, Kingston, ON K7L 2V9  
Phone: 613-533-2999 Fax: 613-533-3078 Email: safety@queensu.ca

**PERSONAL INFORMATION: Please Print**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Department:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email:</td>
<td>Building:</td>
</tr>
<tr>
<td>Job Title:</td>
<td>Workplace/ Day Phone Number:</td>
</tr>
<tr>
<td>Supervisor:</td>
<td>Supervisor’s Phone Number:</td>
</tr>
</tbody>
</table>

**List Airborne Hazards:**  
- ☐ Asbestos  
- ☐ Dust  
- ☐ Biohazard  
- ☐ Silica  
- ☐ Vapour  
- ☐ Other ________________  
- ☐ Isocyanates  
- ☐ Fume

**A. Types of Respirators you are required to use:** (Check all applicable)

- ☐ N95/ P95 – Required Use  
- ☐ N95/ P95 – Personal Choice/ Comfort Use  
- ☐ N100/ P100 – Required Use  
- ☐ N100/ P100 – Personal Choice/ Comfort Use  
- ☐ Self Contained Breathing Apparatus  
- ☐ Half Face Respirator with Cartridges  
- ☐ Full Face Respirator with Cartridges  
- ☐ PAPR

**B. Conditions of Use:** Briefly describe activities performed while wearing a respirator:

- Exertion level during use  
- ☐ Light  
- ☐ Moderate  
- ☐ Heavy

- Frequency of respirator use  
- ☐ Daily  
- ☐ Weekly  
- ☐ Monthly  
- ☐ Annually

- Duration of respirator use in a day  
- ☐ < 15 min  
- ☐ > 15 min  
- ☐ > 2 hr  
- ☐ Variable

- Temperature during use  
- ☐ <0°C  
- ☐ 0 – 25°C  
- ☐ >25°C  
- ☐ Variable

**C. Special Work Considerations:** (Check all applicable one)

**Personal Protective Equipment:**

- Hard Hat  
- Tyvex Suit  
- ☐ Confined Spaces (i.e. tanks/ man holes)  
- Safety Glasses  
- Emergency Escape  
- ☐ Other (Specify): ________________

**Other special work considerations (explain):**

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D. FOR PAPR Respirator, SCBA Respirator Users ONLY (for all other respirator types, proceed to section E):

Health Conditions:
This information is required to assess any medical conditions that you may have which preclude the wearing of a Full Face Respirator, PAPR, SCBA respirator. Further medical examination by a physician may be required if this initial determines the need for medical clearance to wear a respirator.

Do you have any of the following conditions? □ YES □ NO

If you check ‘YES’ please **DO NOT** specify your medical issues(s) on this form

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<td>Emphysema</td>
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<td>Asthma</td>
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<td>Diabetes – Insulin Dependent</td>
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<td>Chest pain when climbing 4 flights of steps or less</td>
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<td>High Blood Pressure/ Medications</td>
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<td>Dizziness/ fainting in hot environment</td>
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E. FOR N95, P95, N100, P100, Half Face Respirator, Full Face Respirator Users ONLY:

Health Conditions:
This information is required to assess any medical conditions that you may have which preclude the wearing of a N95, P95, N100, P100, Half Face Respirator. Further medical examination by a physician may be required if this initial assessment determines the need for medical clearance to wear a respirator.

Do you have any of the following conditions? □ YES □ NO

If you check ‘YES’ please **DO NOT** specify your medical issues(s) on this form

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If I have: an allergy to Latex, wear dentures and/or have any facial skin conditions (i.e. facial acne, eczema), I will advise the fit tester at the time of my testing.

I have answered the questions to the best of my ability and knowledge. I also understand that I am to report any change in my physical health that might affect my ability to wear a respirator to my supervisor and complete a new Health Screening Questionnaire for Respirator Users.

Employee/ Student’s Signature: _______________________________ Date: ________________

____________________________________________________________________________________________

As the supervisor, I have reviewed all work activity hazards (including airborne hazards) with this individual. I have also advised regarding the personal protective equipment required; specifically the use of an appropriate respirator.

Supervisor’s Signature: _______________________________ Date: ________________

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F. Queen’s Department of Environmental Health & Safety Assessment:

Referral required to Health Care Professional?  ☐ YES  ☐ NO

Environmental Health & Safety’s Signature: ___________________________ Date: ________________

G. Health Care Professional (HCP) Primary Assessment (if required) at Walsh & Associates Occupational Health Services, Ltd.

Assessment date: _____________________

Medical Respirator Clearance

☐ Medically cleared for respirator use - no restrictions
☐ Medically cleared for respirator use - some specific restriction (explain):

_____________________________________________________________________________________
_____________________________________________________________________________________

☐ No respirator use permitted (explain):

_____________________________________________________________________________________
_____________________________________________________________________________________

Date

Health Care Professional’s Name

Health Care Professional’s Signature

H. Environmental Health and Safety record of respirator fit test and respirator training.

Respirator fit test date: _____________________ Qualitative test type: Saccharine / Bitrix
Tester:___________________________________ Respirator type: disposable ___________ / ½ face with cartridges / full face with cartridges
Make: ______________________     Model:____________________   Size:_____________________

I attest that I have been fit tested and trained on the use of the respirator listed above. I had an opportunity to ask questions and have had them answered to my satisfaction. I understand and will comply with the following (cross out if not applicable):

☐ I have read and understood SOP-Safety-05 on Respiratory Protection
☐ What type of hazard this respirator will protect me against when used properly.
☐ How to properly don this respirator, including testing for fit each time (must be clean shaven).
☐ How to properly doff this respirator and wash hands after storing or disposing the respirator as appropriate.
☐ How to clean, maintain, and store a reusable respirator (1/2 face or full face).
☐ When I should change the cartridges on a reusable respirator and how to dispose of them.
☐ How to dispose of a disposable respirator when it becomes wet, after wearing for 8 hours, or when I remove it for any reason (whichever comes first).
☐ That I should return to be retested within 2 years of this test or sooner if I experience a greater than 10% change in my body weight; a change in face shape for any reason (e.g. due to an accident or dental work); or significant acne or facial scarring that may affect the fit of this respirator.

_______________________________________  _______________________________________
Print Name of Fit tested person  Signature of Fit tested person