# Health Screening Questionnaire for Respirator Users

## 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:

<table>
<thead>
<tr>
<th>Exertion level during use</th>
<th>Light</th>
<th>Moderate</th>
<th>Heavy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of respirator use</td>
<td>Daily</td>
<td>Weekly</td>
<td>Monthly</td>
</tr>
<tr>
<td>Duration of respirator use in a day</td>
<td>&gt; 15 min</td>
<td>&gt; 2 hr</td>
<td></td>
</tr>
<tr>
<td>Temperature during use</td>
<td>&lt;0°C</td>
<td>0 – 25°C</td>
<td>&gt;25°C</td>
</tr>
</tbody>
</table>

### 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):

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
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

<table>
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<tr>
<th>Condition</th>
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<td>Chest pain when climbing 4 flights of</td>
<td>Dizziness/ fainting in hot environment</td>
</tr>
<tr>
<td>difficulties</td>
<td>steps or less</td>
<td></td>
</tr>
<tr>
<td>Chronic bronchitis</td>
<td>High Blood Pressure/ Medications</td>
<td>Anxiety/ Panic Attacks</td>
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<tr>
<td>Emphysema</td>
<td>Heart/ Cardiac Problems</td>
<td>Back/ neck problems</td>
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<tr>
<td>Asthma</td>
<td>Claustrophobia/ Fear of heights</td>
<td>Muscle or joint problems</td>
</tr>
<tr>
<td>Diabetes – Insulin Dependent</td>
<td>Fainting spells/ Seizures</td>
<td></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: ______________
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: ________________
Tester: ___________________________________ Qualitative test type: Saccharine / Bitrix
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-Lab-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