PARTICULATE RESPIRATOR APPROVAL FORM

VANDERBILT OCCUPATIONAL HEALTH CLINIC
VANDERBILT ENVIRONMENTAL HEALTH & SAFETY
Respiratory Protection Program

Section 1 - Health Questionnaire

To be completed by employee

Name (Please print)________________________________

	Yes	No
1. Do you smoke tobacco?		

2. Have you ever had any of the following conditions? (indicate yes or no for each)

	Yes	No
a. Seizures (fits)		
b. Diabetes (sugar disease)		
c. Allergic reactions that interfere with your breathing		
d. Claustrophobia (fear of closed-in places)		
e. Trouble smelling odors		

3. Have you ever had any of the following pulmonary or lung problems?

	Yes	No
a. Asbestosis		
b. Chronic bronchitis		
c. Emphysema		
d. Lung cancer		
e. Silicosis		
f. Chest injuries or surgeries		
g. Asthma as an adult		
h. Pneumonia in the last month		
i. Tuberculosis (active disease)		
k. Any other lung problem that you've been told about:		

4. Do you **currently** have any of these symptoms of pulmonary or lung illness?

	Yes	No
a. Shortness of breath		
b. Shortness of breath with light activity		
c. Shortness of breath with strenuous activity		
d. Cough that produces thick sputum or blood		
e. Cough lasting longer than 3 weeks		
f. Wheezing		
g. Wheezing that interferes with work		
h. Any other symptoms that may be related to lung problems		

5. Have you ever had any of the following cardiovascular or heart problems?

	Yes	No
a. Heart attack		
b. Stroke		
c. Angina (chest pain)		

5. (Continued)

	Yes	No
d. Heart Failure		
e. Irregular heart beat		
f. Swelling in your legs or feet (**not** caused by walking)		
g. High blood pressure		
h. Any other heart problems		

6. Have you ever had any of the following cardiovascular or heart symptoms?

	Yes	No
a. Frequent pain or tightness in your chest		
b. In the past two years, have you noticed your heart skipping or missing a beat?		
c. Heartburn or indigestion that is not related to eating		
d. Any other symptoms that may be related to heart or circulation problems		

7. Do you **currently** take medication for any of the following problems?

	Yes	No
a. Breathing or lung problems		
b. Heart trouble		
c. Blood pressure		
d. Seizures (fits)		

8. If you've used a respirator, have you ever had any of the following problems? (*If you've never used a respirator, skip question 8 and go to question 9.*)

	Yes	No
a. Eye irritation		
b. Skin allergies or rashes		
c. Anxiety		
d. General weakness or fatigue		
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 survey?		

EMPLOYEE SIGNATURE____ ***Date***___________

---***DO NOT WRITE BELOW THIS LINE***---

COMMENTS____ ***OHC Initials***________

PARTICULATE RESPIRATOR APPROVAL FORM

VANDERBILT OCCUPATIONAL HEALTH CLINIC/VANDERBILT ENVIRONMENTAL HEALTH & SAFETY
Respiratory Protection Program

Section 2 – Employee Information—*To be completed by employee: (Please PRINT)*

PRINT Name: _______ _______ _______ *First* *Middle* *Last*	Last 4 digits of your Social Security Number:
Department:	Supervisor:
Date:	Work Phone:

----------------------------DO NOT WRITE BELOW THIS LINE--------------------

Section 3 – Medical Provider's Written Opinion—*To be completed by Occupational Health*

I. You were evaluated to determine if you are physically able to perform assigned task(s) requiring the use of a particulate filtering respirator (i.e. N-95).

II. Your evaluation revealed the following:

[ ] A. You are approved to wear a particulate respirator **without restrictions** and can progress to the next step of training and equipment fit testing.

[ ] B. You are approved to wear a particulate respirator with the following **restriction(s):**
_____ Do not wear the respirator if wheezing or short of breath.
_____ Notify supervisor if you have difficulty wearing the respirator.

[ ] C. _____ You are **not approved** to wear a particulate respirator.

III. Your next respirator medical evaluation is due:

- If you develop a serious health condition that interferes with using a respirator.
- If there is a change in the workplace condition (e.g., physical labor, protective clothing, temperature) that may substantially increase your physiological work effort.

This faculty/staff member was notified of the results of this evaluation and of any further evaluation or treatment recommended.

_______________________________ _______________________
(Provider Signature) **(Date)**

Section 4 – Respirator Issuance—*To be completed by Environmental Health & Safety*

RESPIRATOR:	
Brand and Model Number:	**Size:**
[ ] Sperian/Willson N-95	[ ] Small
[ ] 3M 1860 (blue)	[ ] Medium
[ ] Other: ______________________	[ ] Large
FITTING:	
[ ] Training for Use Completed by Employee	[ ] Satisfactory Qualitative Bitrex Fit Test
[ ] Satisfactory Qualitative Saccharin Fit Test	[ ] Could not complete fit testing process
[ ] Satisfactory Positive Pressure Fit Check Test	[ ] Declined to participate in fit testing process
Approval Signature:	Date: