University of Vermont Respiratory Protection Program
OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

UVM employees who wear a respirator must complete this form annually and be medically cleared by the University's designated Physician or Licensed Health Care Professionals (PLHCP) who will perform medical evaluations using the information provided on this medical questionnaire. The completed form will be maintained in accordance with the Health Insurance Portability & Accountability Act (HIPPA), which in this case means that only designated PLHCP and clinic staff that require this information to support the employee's health & safety will see and/or maintain medical information will be the only people that have access to these records. Employees found to have risk factors that require further medical evaluation will be contacted by the designated PLHCP to schedule an appointment.

Submission Instructions: Place pages 3-7 of the completed questionnaire in a sealed envelope with your name on the outside and mail it with this page and the signed consent form (next page) in an intra-office envelope to the Respiratory Protection Program Coordinator:

Amy Kutchukian
Risk Management
004 Rowell
Burlington, VT 05405

You must sign the next page to consent to review of your questionnaire

Date: _____ Employee Name: _____ Date of Birth: _____
Job Title: _____ Campus Address: _____
Email Address: _____
Best Phone & Time for Healthcare Provider to reach you: _____

Supervisor Name: _____ Email: _____

University of Vermont

Respiratory Protection Program
OSHA Respirator Medical Evaluation
General Consent for Review and Release of Medical Information

I certify that the statements herein are true, complete, and correct to the best of my knowledge and belief.

I consent to review of this information by Champlain Medical Urgent Care on behalf of the University of Vermont. I understand that this review is undertaken for my safety in the job environment and understand that I may be further contacted by a medical provider either for clarifications or further evaluation. Further evaluation may include, but is not limited to, a physical examination, blood tests, an evaluation of lung function, and other diagnostic tests as necessary. Costs for evaluation and testing will be covered by the University.

I further understand that the determination of whether I can safely wear a respirator will be based on the information gathered and this determination as it relates to my job and the performance of essential job functions will be released to me, my supervisor and the Respiratory Protection Program Coordinator.

Employee Signature: _____

Employee Printed Name: _____

Date Signed: _____

OR

I understand that if I decline participation in the Respiratory Protection Program, my employment status might change to meet acceptable safety and wellbeing standards.

Employee Signature: _____

Employee Printed Name: _____

Date Signed: _____

You will be contacted by Champlain Medical directly if applicable sections are not complete.

Champlain Medical Urgent Care Use Only:

Reviewed by: _____

Date:_____

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: **Can you read (check one): ___Yes ___No**

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 (check 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 healthcare 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 (check 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-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (check 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 check "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 (fits): **__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

f. 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 (fits): 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-face piece 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

Eardrum: __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