RUTGERS
New Jersey Medical School
Occupational Medicine Service

Request for Medical Evaluation for N-95 Respirator Use: Short Form

Section A: COMPLETED BY REQUESTING DEPARTMENT MANAGER OR SUPERVISOR

Employee name (please print):_____
Last First Middle

Employee ID NO. _____

Department:_____ Work location:_____

School/Unit: ☐ CN ☐ GSBS ☐ NJMS ☐ SDM ☐ SHRP ☐ SN ☐ SPH ☐ UBHC ☐ UH_____

Other employer, please specify_____

Supervisor name (print):_____ Supervisor tel #:_____

Models of respirator(s) being considered: N-95_____

Hazardous agent: ☐ TB ☐ Chemical (specify) ☐ Dust/particulate exposure (specify) ☐ Other (specify)

Specify:_____

Level of work effort: ☐ Light ☐ Moderate ☐ Heavy ☐ Strenuous

Extent of usage: ☐ Daily ☐ Occasionally, but more than once a week ☐ Rarely or emergency use only

How many hours a day will respirator be used?_____

Does the employee have a beard or facial hair that may interfere with the use of a respirator? ☐ Yes ☐ No

Special work considerations (e.g., patient lifting requirements, other protective clothing which may add stress):

_____

_____
Department Manager/Supervisor Signature

Section B: COMPLETED BY OCCUPATIONAL MEDICINE SERVICE - Respirator Medical Classification:

Assessment: ☐ Initial ☐ Revision number_____

☐ The individual is medically qualified to use the respirator noted above without limitations/restrictions.

☐ The individual is medically qualified to use the respirator noted above with the following limitations/restrictions:

_____

☐ The individual is currently NOT medically qualified to use the respirator noted above.

☐ Please have the individual contact the Occupational Medicine Service, in SSB Suite GA 167, tel 973.972.2900, fax 973.972.2904, to schedule additional examinations.

☐ Other comments: _____

Evaluator's signature _____ Date:_____

Name (please print):_____

65 Bergen Street, Suite GA-167, P.O. Box 1709
Newark, NJ 07101-1709
Phone: 973.972.2900
Fax: 973.972.2904

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New Jersey Medical School
Occupational Medicine Service

Occupational Safety And Health Administration (OSHA) Respirator Medical Evaluation Questionnaire

SHORT FORM

(Mandatory Appendix C to Sec. 1910.134)

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. **Depending on your supervisor's instructions, either give the completed questionnaire in a sealed envelope to your supervisor to forward it or send it directly to the NJMS Occupational Medicine Service, P.O. Box 1709, SSB Suite GA 167, 65 Bergen Street, Newark NJ 07101-1709, telephone 973.972.2900, fax 973.972.2904, which you can contact for more information.**

If you are to use a respirator other than N-95, please complete the OSHA Respirator Medical Evaluation Questionnaire LONG FORM, which includes additional questions 10-15 and Part B.

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. Date of Birth: _____/_____/_____ 4. Sex (check one): [ ] Male [ ] Female

5. Your height: _____ ft. _____ in. 6. Your weight: _____ pounds

7. Your job title: _____

8. A daytime phone number where you can be reached by the health care professional who reviews this questionnaire (include area code): (_____)_____

9. The best time to phone you at this number: _____ a.m. _____ p.m.

10. Has your employer told you how to contact the health care professional who will review this questionnaire – please see the note above (check one)? [ ] Yes [ ] No

11. Check and specify the type of respirator you will use (you can check more than one category):
    [ ] N respirator (for example, for tuberculosis protection): N-95_____
    [ ] Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus): _____

12. Have you worn a respirator (check one)? [ ] Yes, what type(s)_____ [ ] No

Employee's signature _____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type or respirator. **If you are to use a respirator other than N-95, please see supplemental questions 10-15 and Part B, also.** Please check all that apply.

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? [ ] Yes (specify) [ ] No

[ ] Allergic reactions that interfere with your breathing
[ ] Seizures (fits)
[ ] Diabetes (sugar disease)
[ ] Trouble smelling odors
[ ] Claustrophobia (fear of closed-in places)

3. Have you ever had any of the following pulmonary or lung problems? [ ] Yes (specify) [ ] No

[ ] Asbestosis
[ ] Asthma
[ ] Chronic bronchitis
[ ] Emphysema
[ ] Pneumonia
[ ] Tuberculosis
[ ] Silicosis
[ ] Pneumothorax (collapsed lung)
[ ] Lung cancer
[ ] Broken ribs
[ ] Any chest injuries or surgeries
[ ] Any other lung problem that you've been told about_____

4. Do you currently have any of the following symptoms of pulmonary or lung illness? [ ] Yes [ ] No

[ ] Shortness of breath
[ ] Shortness of breath when walking fast on level ground or up a slight hill or incline
[ ] Shortness of breath when walking with other people at an ordinary pace on level ground
[ ] Have to stop for breath when walking at your own pace on level ground
[ ] Shortness of breath when washing or dressing yourself
[ ] Shortness of breath that interferes with your job
[ ] Coughing that produces phlegm (thick sputum)
[ ] Coughing that wakes you early in the morning
[ ] Coughing that occurs mostly when you are lying down
[ ] Coughing up blood in the last month
[ ] Wheezing
[ ] Wheezing that interferes with your job
[ ] Chest pain when you breathe deeply
[ ] Any other symptoms that you think may be related to lung problems_____

5. Have you ever had any of the following cardiovascular or heart problems? [ ] Yes (specify) [ ] No

[ ] Heart attack
[ ] Stroke
[ ] Angina
[ ] Heart failure
[ ] Swelling in your legs or feet (not caused by walking)
[ ] Heart arrhythmia (heart beating irregularly)
[ ] High blood pressure
[ ] Any other heart problem that you've been told about_____

6. Have you ever had any of the following cardiovascular or heart symptoms? [ ] Yes (specify) [ ] No?

[ ] Frequent pain or tightness in your chest
[ ] Pain or tightness in your chest during physical activity
[ ] Pain or tightness in your chest that interferes with your job
[ ] In the past two years, have you noticed your heart skipping or missing a beat
[ ] Heartburn or indigestion that is not related to eating
[ ] Any other symptoms that you think may be related to heart or circulation problems_____

7. Do you currently take medication for any of the following problems? [ ] Yes (specify) [ ] No

[ ] Breathing or lung problems
[ ] Heart trouble
[ ] Blood pressure
[ ] 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, check the following space and go to question 9.) [ ] Never used a respirator

[ ] Eye irritation
[ ] Skin allergies or rashes
[ ] Anxiety
[ ] General weakness or fatigue
[ ] Any other problem that interferes with your use of a respirator_____

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? [ ] Yes [ ] No