SUNBELT CONTROLS

Appendix 23-A
Respirator Medial Evaluation – Letter to Physician

Employee Name:		**Date:**	
SSN:		**Employee Position:**	
Department / Work Area:			
Health Care Professional:	,M.D.	**Phone Number:**	( ) –

Please examine this employee, who will be using respiratory protection; determine that he or she is physically able to perform the work and use the equipment necessary. The employee will be fitted with the correct type(s) of NIOSH approved respirator(s) for the chemicals and tasks associated with the assignment.

THIS EMPLOYEE MAY BE EXPOSED TO THE FOLLOWING CHEMICALS:

1. _____	**7.** _____
2. _____	**8.** _____
3. _____	**9.** _____
4. _____	**10.** _____
5. _____	**11.** _____
6.	**12.**

REGULAR RESPIRATOR(s) IN USE (for this employee):

- ☐ Half Mask
- ☐ Full Face Mask
- ☐ Disposable Dust Mask
- ☐ Other: _____

The respirator will be used_____hours per day,_____per week.

Confined Space entry is a part of this job:

☐ **YES** ☐ **NO**

EMERGENCY RESPIRATOR(s) POSSIBLY NEEDED:

- ☐ SCBA
- ☐ "Chlorine Sucker"
- ☐ Gas Mask for Escape
- ☐ Other: _____

The employee will be doing the following level(s) of labor:

☐ **LIGHT** ☐ **MODERATE** ☐ **HEAVY**

After the examination, please answer the questions below and return this form with the completed medical evaluation questionnaire to the employee.

1. **Is this employee physically able to perform work while using the required respiratory equipment?**

_____
_____
_____

2. **Are there any restrictions for this employee regarding the wearing of a respirator?**

_____
_____
_____

Further Questions: _____

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***NOTE:** **All employees selected to use any type of respirator must provide the information requested in the questionnaire below. Completion of this questionnaire is conducted during normal working hours or at a time and place that is convenient to you (employee). Completion of this form is a requirement by regulations and shall be provided to the health care professional when evaluated. To maintain your confidentiality, no Sunbelt Controls personnel (or affiliated partners) will actually review your answers – *this information is required for an evaluation by a medical professional and a record maintained*. As such, it will be kept confidential. You will be instructed as to how to deliver or send this questionnaire to the health care professional who will evaluate it.**

PLEASE PRINT

PART A – Section 1			
TODAY'S DATE:		**EMPLOYEE NAME:**	
EMPLOYEE AGE:		**GENDER (check one):**	☐ **MALE** ☐ **FEMALE**

HEIGHT:		**WEIGHT:**	**PHONE NUMBER:**	when is the best time to reach you at this number?
ft.	**in.**	**lbs.**	**( ) –**	

provide a number where you can be reached by the medical provider who is reviewing this questionnaire

HAVE YOU BEEN INFORMED HOW TO CONTACT THE MEDICAL PROFESSIONAL WHO WILL EVALUATE THIS QUESTIONNAIRE?	☐ **YES** ☐ **NO**

CHECK THE RESPIRATOR(s) YOU WILL BE USING (select all that apply):

- ☐ **AIR-SUPPLIED** (tight-fitting)
- ☐ **AIR-SUPPLIED** (hooded)
- ☐ **OPEN-CIRCUIT SCBA**
- ☐ **CLOSED-CIRCUIT SCBA**
- ☐ **COMBINATION AIRLINE/SCBA**
- ☐ **AIR-PURIFYING – POWERED** (tight fitting)
- ☐ **AIR-PURIFYING – POWERED** (hooded)
- ☐ **AIR-PURIFYING – NON-POWERED**

  Filtering face-piece or elastomeric

  N, R, P 95, 99, 100

  type of chemical cartridge _____

HAVE YOU EVER WORN A RESPIRATOR:	☐ **YES** ☐ **NO**	**if yes, what type(s) – describe below:**
		_____ _____ _____

PART A – Section 2		
Do you currently smoke tobacco or have you smoked tobacco in the last month:	☐ **YES**	☐ **NO**
Have you ever suffered any of the following conditions:		
Seizures	☐ **YES**	☐ **NO**
Diabetes (sugar disease)	☐ **YES**	☐ **NO**
Allergic reactions that interfere with your breathing	☐ **YES**	☐ **NO**
Claustrophobia	☐ **YES**	☐ **NO**
Trouble smelling odors	☐ **YES**	☐ **NO**

Appendix 23-A
Respirator Medial Evaluation – Letter to Physician

CONT'D	PART A – Section 2		
Have you ever suffered from any of the following pulmonary or lung problems:			
	Asbestosis	☐ YES	☐ NO
	Asthma	☐ YES	☐ NO
	Chronic Bronchitis	☐ YES	☐ NO
	Emphysema	☐ YES	☐ NO
	Pneumonia	☐ YES	☐ NO
	Tuberculosis	☐ YES	☐ NO
	Silicosis	☐ YES	☐ NO
	Pneumothorax (collapsed lung)	☐ YES	☐ NO
	Lung Cancer	☐ YES	☐ NO
	Broken ribs	☐ YES	☐ NO
	any chest injuries and/or surgeries	☐ YES	☐ NO
Any other lung problems you either have been diagnosed as having, treated for, or suspect you may have:		☐ YES	☐ NO
PLEASE SPECIFY: _____			
Do you currently suffer from any of these symptoms of pulmonary or lung illness:			
	Shortness of breath	☐ YES	☐ NO
	Shortness of breath when:		
	– walking fast on level ground	☐ YES	☐ NO
	– walking up a slight hill or incline	☐ YES	☐ NO
	– both of the above	☐ YES	☐ NO
Need to stop for breaths when walking with others at an ordinary pace on level ground:		☐ YES	☐ NO
Need to stop for breaths when walking at your own pace on level ground:		☐ YES	☐ NO
	Shortness of breath:		
	– when washing or dressing yourself	☐ YES	☐ NO
	– that interferes with your job	☐ YES	☐ NO
Coughing that:			
	– produces phlegm (thick sputum	☐ YES	☐ NO
	– wakes you up early in the morning	☐ YES	☐ NO
	– occurs mostly when you are lying down	☐ YES	☐ NO
Have you coughed up blood in the last month:		☐ YES	☐ NO
Have you experienced wheezing:		☐ YES	☐ NO
Have you experienced that interferes with your job:		☐ YES	☐ NO
Do you experience chest pain when you breathe deeply		☐ YES	☐ NO
Do you have any other symptoms you feel may be related to lung problems:		☐ YES	☐ NO
PLEASE SPECIFY: _____			

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Appendix 23-A
Respirator Medial Evaluation – Letter to Physician

CONT'D **PART A – Section 2**

Have you ever suffered from any of the following cardiovascular or heart problems:

Heart Attack	☐ **YES**	☐ **NO**
Stroke	☐ **YES**	☐ **NO**
Angina	☐ **YES**	☐ **NO**
Heart Failure	☐ **YES**	☐ **NO**
Swelling in legs or feet (not caused by walking)	☐ **YES**	☐ **NO**
Heart Arrhythmia (irregular heartbeat)	☐ **YES**	☐ **NO**
High Blood Pressure	☐ **YES**	☐ **NO**
Any other heart problems you have been either diagnosed as having, treated for and/or suspect you may have:	☐ **YES**	☐ **NO**

PLEASE SPECIFY: _____

_____

_____

_____

Do you currently take medication for any of the following problems:

Breathing or lung problems	☐ **YES**	☐ **NO**
Heart trouble	☐ **YES**	☐ **NO**
Blood Pressure	☐ **YES**	☐ **NO**
Seizures (fits)	☐ **YES**	☐ **NO**

If you have used a respirator, have you ever had any of the following problems: if you've never used a respirator check this box ☐

Eye irritation	☐ **YES**	☐ **NO**
Skin allergies or rashes	☐ **YES**	☐ **NO**
Anxiety	☐ **YES**	☐ **NO**
General weakness or fatigue	☐ **YES**	☐ **NO**
Are there any other problem(s) that interfere(s) with your use of a respirator:	**YES**	**NO**

PLEASE SPECIFY: _____

_____

_____

Would you like to speak with the health care professional who will review and evaluate this questionnaire:	☐ **YES**	☐ **NO**

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***NOTE:** The questions below are to be answered by all those who are selected to use either a Full Face Piece Respirator or a Self-Contained Breathing Apparatus (SCBA). For those who have been selected to use other types of respirators, answering these questions is strictly optional.

PART A – Section 3		
Have you ever lost vision in either eye (temporarily or permanently):	☐ YES	☐ NO
Do you currently have any of the following vision issues / restrictions:		
Contact Lens Wearer	☐ YES	☐ NO
Wearing Glasses	☐ YES	☐ NO
Color Blind	☐ YES	☐ NO
Any other eye or vision impairments:	☐ YES	☐ NO

PLEASE SPECIFY: _____

_____

_____

Have you ever had an injury to your ears, including, but not limited to a broken eardrum:	☐ YES	☐ NO
Do you currently have any of the following hearing issues:		
Difficulty Hearing	☐ YES	☐ NO
Hearing Aid Wearer	☐ YES	☐ NO
Any other hearing or ear related issues or impairments:	☐ YES	☐ NO

PLEASE SPECIFY: _____

_____

_____

Have you ever had a back injury:	☐ YES	☐ NO

PLEASE SPECIFY: _____

_____

Do you currently have any of the following musculoskeletal issues:		
Weakness in any of your arms, hands, legs or feet	☐ YES	☐ NO
Back Pain	☐ YES	☐ NO
Difficulty moving your arms and/or legs	☐ YES	☐ NO
Pain or stiffness when bending at the waist either forward or backward	☐ YES	☐ NO
Difficulty fully moving your head up or down	☐ YES	☐ NO
Difficulty fully moving your head side-to-side	☐ YES	☐ NO
Difficulty bending at the knees	☐ YES	☐ NO
Difficulty squatting to the ground	☐ YES	☐ NO
Difficulty climbing a flight of stairs or ladder carrying more than 25lbs.	☐ YES	☐ NO
Any other muscle or skeletal issues which would interfere or otherwise restrict usage of a respirator:	☐ YES	☐ NO

PLEASE SPECIFY: _____

_____

_____

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***NOTE:** **The following questions are to be completed at the discretion of the Health Care Professional t a s k e d with evaluating this questionnaire. Not all questions need be answered.**

PART B – Section 1

In your present job/position are you working at high altitudes (over 5,000ft) or in a place that has lower than normal amounts of oxygen:	☐ **YES**	☐ **NO**
(IF YES ⓪) **Do you ever experience feelings of dizziness, shortness of breath, pounding in your chest or any other symptoms while working under these conditions:**	☐ **YES**	☐ **NO**
Either at work or at home, are you or have you ever been, exposed to hazardous solvents, hazardous airborne chemicals (i.e. gases, fumes, or dust) or contact with hazardous	☐ **YES**	☐ **NO**

IF YES ⓪ NAME THE CHEMICALS (IF YOU KNOW THEM)

Have you ever worked with any of the materials or under any of the following conditions:

Asbestos	☐ **YES**	☐ **NO**
Silica	☐ **YES**	☐ **NO**
Tungsten/Cobalt (i.e. grinding and/or welding this material**)**	☐ **YES**	☐ **NO**
Beryllium	☐ **YES**	☐ **NO**
Aluminum	☐ **YES**	☐ **NO**
Coal (i.e. mining operations**)**	☐ **YES**	☐ **NO**
Iron	☐ **YES**	☐ **NO**
Tin	☐ **YES**	☐ **NO**
Dusty Environments	☐ **YES**	☐ **NO**
Any other hazardous exposures in regards to material, chemicals, environmental working conditions:	☐ **YES**	☐ **NO**

PLEASE SPECIFY: _____

_____

_____

_____

_____

List any second jobs and/or side businesses you have or with which you are engaged:

_____

_____

List your previous occupation(s):

_____

_____

List your current and past hobbies:

_____

_____

_____

CONT'D	PART B – Section 1		
Have you ever served in the military:		☐ YES	☐ NO
(IF YES ⓪) **Were you exposed to biological or chemical agents either in training or during combat:**		☐ YES	☐ NO
IF YES ⓪ NAME THE CHEMICALS (IF YOU KNOW THEM)			
Have you ever worked on a HAZMAT team:		☐ YES	☐ NO
Other than medications detailed earlier in this questionnaire for breathing and/or lung problems, heart issues, blood pressure and seizures, are you currently taking any other medications for any reason:		☐ YES	☐ NO
IF YES ⓪ NAME THE MEDICATIONS (IF YOU KNOW THEM)			

Will you be using any of the following items with your respirators:

HEPA filters	☐ YES	☐ NO
Canisters (i.e. gas masks**) Cartridges**	☐ YES	☐ NO
	☐ YES	☐ NO

How often are you anticipating use of a respirator(s) CHECK 'YES' OR 'NO' FOR ALL THAT APPLY:

Escape Only (no rescue**)**	☐ YES	☐ NO
Emergency Rescue Only	☐ YES	☐ NO
Less than 5-hours per week	☐ YES	☐ NO
Less than 2-hours per week	☐ YES	☐ NO
2 – 4 hours per day	☐ YES	☐ NO
Over 4-hours per day	☐ YES	☐ NO

During the respirator use period is your work load expected to be:

Light (less than 200kcal per hour**)**	☐ YES	☐ NO

IF YES ⓪ **how long does this period last during an average shift:_____hours_____minutes**

Examples of light work are – sitting while writing, typing, and drafting or performing light assembly work; standing while operating a drill press (1 – 3lbs) or controlling machines

During the respirator use period is your work load expected to be:

Moderate (200 – 300kcal per hour**)**	☐ YES	☐ NO

IF YES ⓪ **how long does this period last during an average shift:_____hours_____minutes**

Examples of moderate work are – sitting while nailing or filing; driving truck or bus in urban traffic; standing while drilling, nailing, performing assembly work or transferring a moderate load (about 35lbs) at trunk level; walking on a level surface about 2-mph or down a 5° grade about 3-mph; or pushing a wheelbarrow with a heavy load (about 100lbs) on a level surface

Appendix 23-A
Respirator Medial Evaluation – Letter to Physician

CONT'D	PART B – Section 1

During the respirator use period is your work load expected to be:

Heavy (above 350kcal per hour**)** ☐ **YES** ☐ **NO**

IF YES ◎ **how long does this period last during an average shift:_____________hours_____________minutes**

Examples of heavy work are – lifting a heavy load (about 50lbs) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8° grade about 2-mph; climbing stairs with a heavy load (about 50lbs)

Will you be wearing protective clothing and/or additional equipment (other than the respirator): ☐ **YES** ☐ **NO**

IF YES ◎ DESCRIBE THIS PROTECTIVE CLOTHING AND/OR EQUIPMENT ____

Will you be working in hot conditions (temperatures exceeding 77°F): ☐ **YES** ☐ **NO**

Will you be working under humid conditions: ☐ **YES** ☐ **NO**

DESCRIBE THE WORK YOU ARE EXPECTED TO DO WHILE USING THE RESPIRATOR(s) ____

DESCRIBE SPECIAL OR HAZARDOUS CONDITIONS YOU MIGHT ENCOUNTER (i.e. CONFINED SPACES, LIFE-THREATENING GASES, etc.) ____

Provide the requested information for each toxic substance you expect to be exposed to while performing the work requiring a respirator:

TOXIC SUBSTANCE (**NAME**): __________	TOXIC SUBSTANCE (**NAME**): __________
EST. MAX EXPOSURE LEVEL PER SHIFT: __________	EST. MAX EXPOSURE LEVEL PER SHIFT: __________
DURATION OF EXPOSURE PER SHIFT: __________	DURATION OF EXPOSURE PER SHIFT: __________
TOXIC SUBSTANCE (**NAME**): __________	TOXIC SUBSTANCE (**NAME**): __________
EST. MAX EXPOSURE LEVEL PER SHIFT: __________	EST. MAX EXPOSURE LEVEL PER SHIFT: __________
DURATION OF EXPOSURE PER SHIFT: __________	DURATION OF EXPOSURE PER SHIFT: __________
TOXIC SUBSTANCE (**NAME**): __________	TOXIC SUBSTANCE (**NAME**): __________
EST. MAX EXPOSURE LEVEL PER SHIFT: __________	EST. MAX EXPOSURE LEVEL PER SHIFT: __________
DURATION OF EXPOSURE PER SHIFT: __________	DURATION OF EXPOSURE PER SHIFT: __________
TOXIC SUBSTANCE (**NAME**): __________	TOXIC SUBSTANCE (**NAME**): __________
EST. MAX EXPOSURE LEVEL PER SHIFT: __________	EST. MAX EXPOSURE LEVEL PER SHIFT: __________
DURATION OF EXPOSURE PER SHIFT: __________	DURATION OF EXPOSURE PER SHIFT: __________

Appendix 23-A
Respirator Medial Evaluation – Letter to Physician

CONT'D	PART B – Section 1
THE NAME OF ANY OTHER TOXIC SUBSTANCES YOU ***MAY*** BE EXPOSED TO WHILE USING YOUR RESPIRATOR	
DESCRIBE AN SPECIAL RESPONSIBILITIES YOU'LL HAVE WHILE USING YOUR RESPIRATOR THAT MAY AFFECT THE SAFETY AND WELL BEING OF OTHERS (i.e. RESCUE TEAM, SECURITY, etc.)	

Appendix 23-A
Respirator Medial Evaluation – Letter to Physician

EMPLOYEE CERTIFICATION

I hereby certify, to the best of my knowledge, that all of the answered questions and statements made on the ***Respirator Medical Evaluation*** questionnaire are correct and true.

_____ _____

Employee Signature Date

_____

Employee Name (please print)

PHYSICIAN CERTIFICATION

Based on my review of the ***Respirator Medical Evaluation*** questionnaire, the named employee ☐ **is** | ☐ **is not** *(please check applicable box)* qualified to wear the respirator requested on page one (1) of this document.

_____ _____

Licensed Health Care Professional Signature Date

_____

Licensed Health Care Professional Name (please print)