COUNTY OF LOS ANGELES
DEPARTMENT OF HUMAN RESOURCES
OCCUPATIONAL HEALTH PROGRAMS

EMPLOYEE MEDICAL EVALUATION CLEARANCE FORM FOR RESPIRATOR USE

Mandatory Policy: Before being fit tested or required to use a respirator at work, each employee must undergo confidential medical evaluation for the ability to wear a respirator and the department must obtain and give the employee a copy of this form with the written medical recommendation of the Occupational Health Programs (OHP) Reviewing Physician.

Instructions to Department: As the employer, you (and not the employee) are required to complete the following information needed by the OHP Reviewing Physician pertaining to the employee's identity and expected respirator use. Please type or use black ink and print legibly. Attach this form to the front of the confidential medical history questionnaire form and instruct the employee to complete the questionnaire and to mail both documents to OHP, 3333 Wilshire Boulevard, 10th Floor, Los Angeles, CA 90010.

Employee Name (Last, First M.I.): _____ SS#: _____

Department: _____ Job Title: _____ Hire Date: _____

1. Type and weight of respirator to be used: _____

2. Duration and frequency of respirator use (including use for rescue and escape): _____

3. Expected work effort of employee (please circle): Light Moderate Heavy

4. Additional protective clothing and equipment employee will wear with respirator: _____

5. Temperature (>77 FO) and/or humidity extremes employee may encounter: _____

6. Will employee work at high altitudes (over 5,000 feet) or in a place with lower than normal oxygen? Yes ☐ No ☐

7. Hazardous exposures expected (please specify reason for respirator): _____

8. Type of work employee will be doing using respirator: _____

Person in Department supplying this information

_____ _____ _____ _____ _____

Signature | Name (Please Print) | Title | Phone No. | Date Signed

********** SECTION BELOW FOR OHP USE ONLY (Do Not Tear Off) **********

Medical questionnaire reviewed by _____ on date _____

TO THE EMPLOYEE'S DEPARTMENT:

Physician's Written Recommendation For Respirator Use

1. Is this employee medically able to use the respirator? Yes ☐ No ☐

   If yes, any limitations on respirator use related to the medical condition of the employee or relating to the workplace conditions in which the respirator will be used: None ☐ Other _____

2. Does this employee need follow-up medical evaluation? No ☐ Yes ☐ required on date: _____

3. A copy of this written recommendation for the employee is provided (attached).

_____ _____ _____

Signature of OHP Reviewing Physician | Date Signed | Date OHP Mailed to Department

STOP! Do not complete the rest of this form unless signed by the OHP Physician. **The department is responsible for giving the copy to the employee and is advised to obtain employee signature of receipt.**

Date Dept. gave copy to employee _____ By (Initial or Sign) _____

To The Employee: Please read this form carefully. **If you have any questions,** please call the OHP name at (213) 738 -2186.

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Name: _____
Last First Initial.

Number: _____

Birthdate: _____ Age: _____

Position Tide: _____ Item # _____

To the Employee:

Can you read? Yes ☐ No ☐
If "No" who helped you to understand and complete this questionnaire?
Name _____ Relationship _____

Your employer must allow you to answer the 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 ft.

Part A. Section 1. 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. Sex (circle one) Male Female
3. Your height _____ ft. _____ inch.
4. Your weight: _____lbs.
5. A phone number where you can be reached by the health care professional who reviews questionnaire (include the area code):_____
6. The best time to phone you at this number: _____
7. Has your employer told you how to contact the health care professional who will review this questionnaire? Yes ☐ No ☐

Part A. Section 2 Please answer each question by circling "Yes" or "No" and placing a check-mark next to those conditions which apply.

Please circle

Yes No 1. Do you currently smoke tobacco, or have you smoked tobacco in the past month?

Yes No 2. Have you ever had any of the following conditions?
If "Yes", check all that apply

- ☐ 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

Name: _____

Yes No 3. Have you ever had any of the following pulmonary or lung problems?
If "Yes" check all that apply

- ☐ a. Asbestosis;
- ☐ b. Asthma
- ☐ c. Chronic bronchitis
- ☐ d. Emphysema
- ☐ e. Pneumonia
- ☐ f. Tuberculosis
- ☐ g. Silicosis
- ☐ h. Pneumothorax (collapsed lung)
- ☐ i. Lung cancer
- ☐ j. Broken ribs
- ☐ k . Any chest injuries or surgeries
- ☐ l. Any other lung problem that you've been told about (Please describe)

_____
_____

Yes No 4. Do you currently have any of the following symptoms of pulmonary or lung illness?
If "yes" check all that apply.

- ☐ a. Shortness of breath
- ☐ b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
- ☐ c. Shortness of breath when walking with other people at an ordinary pace on level ground
- ☐ d. Have to stop for breath when walking at your own pace on level ground
- ☐ e. Shortness of breath when washing or dressing yourself
- ☐ f. Shortness of breath that interferes with your job
- ☐ g. Coughing that produces phlegm (thick sputum)
- ☐ h. Coughing that wakes you early in the morning
- ☐ i. Coughing that occurs mostly when you are lying down
- ☐ J. Coughing up blood in the last month
- ☐ k. Wheezing
- ☐ l. Wheezing that interferes with your job
- ☐ m. Chest pain when you breathe deeply
- ☐ n. Any other symptoms that you think may be related to lung problems (Please describe) _____

_____
_____

Yes No 5. Have you ever had any of the following cardiovascular or heart problems?
If "Yes" check all that apply

- ☐ a. Heart attack
- ☐ b. Stroke
- ☐ c. Angina
- ☐ d. Heart failure
- ☐ e. Swelling in your legs or feet (not caused by walking)
- ☐ f. Heart arrhythmia (heart beating irregularly)
- ☐ g. High blood pressure
- ☐ h. Any other heart problem that you've been told about. (Please describe)

_____
_____
_____

Name: _____

Yes No 6. Have you ever had any of the following cardiovascular or heart symptoms?
If 'Yes' check all that apply
- ☐ a. Frequent pain or tightness in your chest
- ☐ b. Pain or tightness in your chest during physical activity job
- ☐ c. Pain or tightness in your chest that interferes with your job
- ☐ d. In the Past two years, have you noticed your heart skipping or missing a beat
- ☐ e. Heartburn or indigestion that is not related to eating
- ☐ f. Any other symptoms that you think may be related to heart or circulation problems? (Please describe) _____

Yes No 7. Do you currently take medication for any of the following problems?
If 'Yes' check all that apply
- ☐ a. Breathing or lung problems
- ☐ b. Heart trouble
- ☐ c. Blood pressure
- ☐ d. Seizures (fits)

Yes No 8. I have used a respirator before. If "No" please skip to question 10.

Yes No 9. If you've ever used a respirator, have you ever had any of the following problems? Please check all that apply
- ☐ 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 (Please describe) _____

Yes No 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?
If "yes" check all that apply
- ☐ a. Wear contact lenses
- ☐ b. Wear glasses
- ☐ c. Color blind
- ☐ d. Any other eye or vision problem (Please describe) _____

Yes No 12. Have you ever had an injury to your ears, including a broken ear drum?

Yes No 13. Do you currently have any of the following hearing problems?
If "Yes" check all that apply
- ☐ a. Difficulty hearing
- ☐ b. Wear a hearing aid
- ☐ c. Any other hearing or ear problem (Please describe) _____

Yes No 14. Have you ever had a back injury?

Name: _____

Yes No 15. Do you currently have any of the following musculoskeletal problems?
If "yes" check all that apply

- ☐ a. Weakness in any of your arms, hands, legs, or feet?
- ☐ b. Back pain
- ☐ c. Difficulty fully moving your arms and legs
- ☐ d. Pain and stiffness when you lean forward or backward at the waist
- ☐ e. Difficulty fully moving your head up or down
- ☐ f. Difficulty fully moving your head from side to side
- ☐ g. Difficulty bending at your knees
- ☐ h. Difficulty squatting to the ground
- ☐ i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.
- ☐ j. Any other muscle or skeletal problem that interferes with using a respirator (Please describe) _____

_____

_____

If you need to describe a problem in more detail, please use the space below:

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