



## KSU Respirator Medical Evaluation Questionnaire

### KSU Respiratory Protection Program

Respirators must be used in workplaces where employees are exposed to hazardous airborne contaminants. When respiratory protection is required, employees **must** enroll in the KSU Respiratory Protection Program [per 29 CFR 1910.134] using the EHS Initial Respirator Clearance and Enrollment form. Before wearing a respirator, workers must first be medically evaluated using the attached Medical Questionnaire and approved by the healthcare provider as documented in the KSU Initial Respirator Clearance and Enrollment Form. Before using respiratory protection, the worker must receive training. To determine if respiratory protection is needed, a workplace exposure assessment must be performed by KSU EHS or their designee.

Alternately, EHS may make this determination based on existing quantitative data, or based on area and/ or activity-specific procedure or policy requiring respirator use.

### OSHA Medical Evaluation and Questionnaire Regulatory Requirements

#### *adopted for KSU by reference*

- The employer must identify a physician or other licensed health care professional (PLHCP) to perform all medical evaluations using the medical questionnaire in Appendix C of the Respiratory Protection standard or a medical examination that obtains the same information. (See Paragraph (e)(2) (i).)
- The medical evaluation must obtain the information requested in Sections 1 and 2, Part A of Appendix C. The questions in Part B of Appendix C may be added at the discretion of the health care professional. (See Paragraph (e)(2)(ii).)
- The employer must ensure that a follow-up medical examination is provided for any employee who gives a positive response to any question among questions 1 through 8 in Part A Section 2, of Appendix C, or whose initial medical examination demonstrates the need for a follow-up medical examination. The employer must provide the employee with an opportunity to discuss the questionnaire and examination results with the PLHCP. (See Paragraph (e)(3)(i).)
- The medical questionnaire and examinations must be administered confidentially during the employee's normal working hours or at a time and place convenient to the employee and in a manner that ensures that he or she understands its content. The employer must not review the employee's responses, and the questionnaire must be provided directly to the PLHCP. (See Paragraph (e)(4)(i).)
- The PLHCP provides the employer with an approval for the employee to use respiratory protection.

For additional information contact KSU Environmental Health and Safety at 785-532-5856 or visit [www.ksu.edu/safety](http://www.ksu.edu/safety).

### Reference Appendix C of 29 CFR 1910.134: OSHA Respirator Medical Evaluation Questionnaire

**Employer:** By regulation, answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination. Under the discretion of the PLHCP, additional examination or testing may be required to make a final determination on the employee's ability to use a respirator.

**Employee:** 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 supervisor must not look at or review your answers. Your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it and/or where to go to for testing/examination by the health care professional if indicated.

**Once filled out, the attached questionnaire must be given to the PLHCP. This form should not be submitted to the supervisor or OSHA. Using the Initial Respirator Clearance form, the PLHCP must provide KSU EHS with an approval indicating the employee is cleared to wear the type(s) of respiratory protection indicated.**



## KSU Respirator Medical Evaluation Questionnaire

**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 (circle 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 health care 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 (circle 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-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (circle 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 circle "yes" or "no").

	YES	NO
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had any of the following conditions?		
a. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
b. Diabetes (sugar disease)	<input type="checkbox"/>	<input type="checkbox"/>
c. Allergic reactions that interfere with your breathing	<input type="checkbox"/>	<input type="checkbox"/>
d. Claustrophobia (fear of closed-in places)	<input type="checkbox"/>	<input type="checkbox"/>
e. Trouble smelling odors	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
c. Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
d. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
e. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>

*This document was modified by KSU from OSHA INFOSHEET 3789-05 2015.*



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	YES	NO
f. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
g. Silicosis	<input type="checkbox"/>	<input type="checkbox"/>
h. Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>
i. Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>
j. Broken ribs	<input type="checkbox"/>	<input type="checkbox"/>
k. Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/>
l. Any other lung problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/>	<input type="checkbox"/>
c. Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
d. Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
e. Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>
f. Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
g. Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>
h. Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>
i. Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/>
j. Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/>
k. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
l. Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
m. Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/>
n. Any other symptoms that you think may be related to lung problems	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had any of the following cardiovascular or heart problems?		
a. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
b. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
c. Angina	<input type="checkbox"/>	<input type="checkbox"/>
d. Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
e. Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/>	<input type="checkbox"/>
f. Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/>	<input type="checkbox"/>
g. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
h. Any other heart problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest	<input type="checkbox"/>	<input type="checkbox"/>
b. Pain or tightness in your chest during physical activity	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain or tightness in your chest that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past two years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/>	<input type="checkbox"/>
e. Heartburn or indigestion that is not related to eating	<input type="checkbox"/>	<input type="checkbox"/>
f. Any other symptoms that you think may be related to heart or circulation problems	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you currently take medication for any of the following problems?		
a. Breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
b. Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
c. Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
d. Seizures	<input type="checkbox"/>	<input type="checkbox"/>

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	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.)	<input type="checkbox"/>	<input type="checkbox"/>
a. Eye irritation	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin allergies or rashes	<input type="checkbox"/>	<input type="checkbox"/>
c. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
d. General weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>
e. Any other problem that interferes with your use of a respirator	<input type="checkbox"/>	<input type="checkbox"/>
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	<input type="checkbox"/>	<input type="checkbox"/>

**Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece 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)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you currently have any of the following vision problems?		
a. Wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
b. Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>
c. Color blind	<input type="checkbox"/>	<input type="checkbox"/>
d. Any other eye or vision problem	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever had an injury to your ears, including a broken eardrum?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you currently have any of the following hearing problems?		
a. Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>
b. Wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>
c. Any other hearing or ear problem	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had a back injury?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you currently have any of the following musculoskeletal problems?		
a. Weakness in any of your arms, hands, legs, or feet	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain	<input type="checkbox"/>	<input type="checkbox"/>
c. Difficulty fully moving your arms and legs	<input type="checkbox"/>	<input type="checkbox"/>
d. Pain and stiffness when you lean forward or backward at the waist	<input type="checkbox"/>	<input type="checkbox"/>
e. Difficulty fully moving your head up or down	<input type="checkbox"/>	<input type="checkbox"/>
f. Difficulty fully moving your head side to side	<input type="checkbox"/>	<input type="checkbox"/>
g. Difficulty bending at your knees	<input type="checkbox"/>	<input type="checkbox"/>
h. Difficulty squatting to the ground	<input type="checkbox"/>	<input type="checkbox"/>
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>
j. Any other muscle or skeletal problem that interferes with using a respirator	<input type="checkbox"/>	<input type="checkbox"/>



## KSU Respirator Medical Evaluation Questionnaire

**Part B. (Optional)** Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes/No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes/No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No

If "yes," name the chemicals if you know them:

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3. Have you ever worked with any of the materials, or under any of the conditions, listed below?

- a. Asbestos: Yes/No
- b. Silica (e.g., in sandblasting): Yes/No
- c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No
- d. Beryllium: Yes/No
- e. Aluminum: Yes/No
- f. Coal (for example, mining): Yes/No
- g. Iron: Yes/No
- h. Tin: Yes/No
- i. Dusty environments: Yes/No
- j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures:

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4. List any second jobs or side businesses you have:

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5. List your previous occupations:

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6. List your current and previous hobbies:

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7. Have you been in the military services? Yes/No

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you ever worked on a HAZMAT team? Yes/No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes/No

If "yes," name the medications if you know them:

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10. Will you be using any of the following items with your respirator(s)?

- a. HEPA Filters: Yes/No
- b. Canisters (for example, gas masks): Yes/No
- c. Cartridges: Yes/No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?

- a. Escape only (no rescue): Yes/No
- b. Emergency rescue only: Yes/No
- c. Less than 5 hours *per week*: Yes/No
- d. Less than 2 hours *per day*: Yes/No
- e. 2 to 4 hours per day: Yes/No
- f. Over 4 hours per day: Yes/No

12. During the period you are using the respirator(s), is your work effort:

a. *Light* (less than 200 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

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

b. *Moderate* (200 to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or *pushing* a wheelbarrow with a heavy load (about 100 lbs.) on a level surface. c. *Heavy* (above 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

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



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13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No      If "yes," describe this protective clothing and/or equipment:

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14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No

15. Will you be working under humid conditions: Yes/No

16. Describe the work you'll be doing while you're using your respirator(s):

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17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

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18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

Name of the second toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

Name of the third toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

The name of any other toxic substances that you'll be exposed to while using your respirator:

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19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):