Annual Respiratory Protection Questionnaire

This questionnaire must be completed by all UCB employees who will be using any NIOSH-approved respirator. Please complete the questionnaire and then hand to the person performing your fit test. It will be returned to the Occupational Health Clinic at the completion of your fit test.

Name: ____________________________________________

Date of Birth: ___ / ___ / ___ Supervisor: ____________________ Department __________________

Work phone number __________________ Home phone number __________________

Since your last medical clearance for use of a respiratory protection device, have you: (circle one)

1. Had a heart attack? Yes No
2. Had a chest pain or shortness of breath when climbing 2 flights of stairs? Yes No
3. Had asthma or wheezing which is not well-controlled with medication? Yes No
4. Had a fainting spell or a seizure? Yes No
5. Grown a mustache or beard/developed any facial deformity? Yes No
6. Had a notable change in workplace exposure to airborne hazards? Yes No

____________________________________________________________________

7. Do you have concerns about your medical ability to wear a respirator? Yes No
8. Do you wish to talk to an Occupational Health Clinic provider about any other aspect of your medical clearance to wear a respirator? Yes No

If you answered 'yes' to any of the above questions, please ask your EH&S Safety Specialist or Safety Specialist to assist you in making an appointment with the Occupational Health Clinic.

Additionally, please inform the EH&S specialist if you have any concerns regarding respiratory protection including fit, selection, use, and maintenance.

Signature ___________________________ Date ___ / ___ / ___

12/8/2010