Attachment 5

UNIVERSITY HEALTH SERVICES
Tang Center
People. Campus. Community.

Occupational Health Clinic

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

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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 ___/___/___

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