RESPIRATOR PROGRAM
RESPIRATOR USER HEALTH SCREENING FORM

EHS-RP-F6-R1

1. Respirator User Contact Information

First name: Last name:

Job title or role (e.g. custodian, pharmacy student): Department:

Faculty ☐ Staff ☐ Student ☐ Visitor ☐ Other:

Phone number: Email address:

Student or employee number: Supervisor's name:

2. Conditions of Use

Activities requiring respirator use:

Frequency of respirator use:
daily ☐ weekly ☐ monthly ☐ yearly ☐ uncertain ☐

Level of physical exertion:
light ☐ moderate ☐ heavy ☐ other ☐

Duration of respirator use per shift:
less than 15 minutes ☐ 15 minutes – 2 hours ☐ more than 2 hours ☐ uncertain ☐

Temperature during use:
less than 0 °C ☐ 0 – 25 °C ☐ more than 25 °C ☐

Atmospheric pressure during use:
reduced ☐ normal (ambient) ☐ increased ☐

Special work considerations:

emergency escape ☐ confined space entry ☐ healthcare ☐ oxygen deficiency ☐

immediately dangerous to life or health (IDLH) ☐ other ☐ please specify_____

Other PPE required during respirator use:

3. Types of Respirators to be Used	
☐ disposable/filtering facepiece (e.g. N95)	☐ supplied-air, pressure demand
☐ tight fitting (half or full face piece)	☐ SCBA - escape
☐ non-tight fitting face piece (e.g. hood)	☐ SCBA - open circuit
☐ mouth piece	☐ SCBA - closed circuit
☐ air purifying -non-powered	☐ combination - pressure demand/supplied air with escape
☐ air-purifying - powered	☐ combination - supplied-air with air purifying elements
☐ supplied-air, demand	☐ supplied-air suit
☐ supplied-air, continuous flow	☐ other, please specify
☐ supplied-air, pressure demand	_____

Signature of Supervisor:

Date:

4. Respirator User Health Information

a) Some medical conditions can seriously affect your ability to safely use a respirator.

PLEASE DO NOT SPECIFY HEALTH CONDITION ON THIS FORM

Review the list below and then check either YES or NO if you experience any of the following conditions, or any other condition that may affect your ability to use a respirator.

YES ☐ NO ☐

Shortness of breath	Cardiovascular disease	Allergies
Chronic bronchitis	Diabetes	Temperature susceptibility
Lung disease	Fainting spells	Claustrophobia
Heart problems	Seizures	Dentures
Hypertension	Panic attacks	Colour blindness
Thyroid problems	Fear of heights	Pacemaker
Neuromuscular disease	Hearing impairment	Unusual Facial features/skin conditions
Dizziness/nausea	Asthma	Prescription medication to control a condition
Breathing difficulties	Reduced sense of smell	Vision impairment (Not applicable to wearing
Emphysema	Reduced sense of taste	N95 & half face masks)
Chest pain on exertion	Back/neck problems	Other condition(s) affecting respirator use

b) have you had previous difficulty while using a respirator? yes ☐ no ☐ never worn ☐

c) do you have any concerns about your future ability to use a respirator safely?
yes ☐ no ☐ never worn ☐

Note: If you answer “Yes” to questions “a”, “b” or “c” fit testing cannot be performed and a further assessment by the Occupational Health Nurse is required.

Signature of respirator user:

Date:

5. Occupational Health Nurse - primary assessment
Assessment date:
Respirator use permitted: yes ☐ no ☐ uncertain ☐
Referred to medical assessment: yes ☐ no ☐
Comments:
Reassessment date:
Name of Occupational Health Nurse (print please):
Signature of Occupational Health Nurse:
Date:
6. Medical Assessment
Assessment date:
Restrictions: ☐ no restrictions ☐ some specific restrictions apply: ☐ respirator use not permitted:
Name of physician (print please):
Signature of physician:
Date: