

**UCSF MEDICAL CENTER  
 OCCUPATIONAL HEALTH SERVICES  
 1600 Divisadero St. Box 1661  
 San Francisco, CA 94115  
 (415) 885-7580**

**TB Respirator Clearance** (2/6/08)

<b>TO BE COMPLETED BY OCCUPATIONAL HEALTH SERVICES</b>	
<input type="checkbox"/> Approved for fit testing	<input type="checkbox"/> Not Approved (Referred for further medical evaluation)
Restriction or Comments: _____ N95 or PAPR _____	
Clinician Signature	Date

**ALL INFORMATION MUST BE COMPLETED BY EMPLOYEE FOR RESPIRATOR APPROVAL:**

Last Name:	First Name:	Date of Birth:

Department/Unit:	Job Title:	Work Phone:	Last 4 digits of SSN:  XXX - XX -

OSHA Long Form Completed – on file in Occupational Health Services

**UCSF Medical Center**

Occupational Health Services  
2380 Sutter, 3<sup>rd</sup> Floor Box 1661  
Phone: (415) 885-7580  
Fax: (415) 771-4472

**Respirator Medical Evaluation Questionnaire – N95 (Respiratory Isolation Mask) (1/3/07)****Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)**

**To the employee:** Can you read? (circle one): Yes / No

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 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 it.

**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).

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Marital Status: \_\_\_\_\_ Social Sec #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(For registration purposes only)

Phone # (where you can be reached by the health care professional who reviews this questionnaire): \_\_\_\_\_

The best time to reach you at this number: \_\_\_\_\_ Alternate #: \_\_\_\_\_

Job Title: \_\_\_\_\_ Department: \_\_\_\_\_ Email: \_\_\_\_\_

Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Birthdate: mm/dd/yy \_\_\_\_\_

Employer (check one): UCSF Medical Center \_\_\_\_\_ UCSF Campus \_\_\_\_\_ LPPI \_\_\_\_\_ Traveler \_\_\_\_\_

Other \_\_\_\_\_

1. Has your employer told you how to contact the health care professional who will review this questionnaire?  
(circle one) Yes / No
2. 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 indicate "yes" or "no").

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month? Yes No
2. Have you *ever had* any of the following conditions?
  - a) Seizures (fits) Yes No
  - b) Diabetes (sugar disease) Yes No
  - c) Allergic reaction that interfere with your breathing Yes No
  - d) Claustrophobia (fear of closed-in places) Yes No
  - e) Trouble smelling odors Yes No
3. Have you *ever had* any of the flowing pulmonary or lung problems?
  - a) Asbestosis Yes No
  - b) Asthma Yes No
  - c) Chronic bronchitis Yes No
  - d) Emphysema Yes No
  - e) Pneumonia Yes No
  - f) Tuberculosis Yes No
  - g) Silicosis Yes No
  - h) Pneumothorax (collapsed lung) Yes No
  - i) Lung cancer Yes No
  - j) Broken ribs Yes No
  - k) Any chest injuries or surgeries Yes No
  - l) Any other lung problem that you've been told about Yes No

**Please complete the back of this form...turn the page...thanks!**

4. Do you currently have any of the following symptoms of pulmonary or lung illness
- a) Shortness of breath Yes No
  - b) Shortness of breath when walking fast on level ground or walking up a slight hill or incline Yes No
  - c) Shortness of breath when walking with other people at an ordinary pace on level ground Yes No
  - d) Have to stop for breath when walking at your own pace on level ground Yes No
  - e) Shortness of breath when washing or dressing yourself Yes No
  - f) Shortness of breath that interferes with your job Yes No
  - g) Coughing that produces phlegm (thick sputum) Yes No
  - h) Coughing that wakes you early in the morning Yes No
  - i) Coughing that occurs mostly when you are lying down Yes No
  - j) Coughing up blood in the last month Yes No
  - k) Wheezing Yes No
  - l) Wheezing that interferes with your job Yes No
  - m) Chest pain when you breathe deeply Yes No
  - n) Any other symptoms that you think may be related to lung problems Yes No

5. Have you *ever had* any of the following cardiovascular or heart problems?
- a) Heart attack Yes No
  - b) Stroke Yes No
  - c) Angina Yes No
  - d) Heart failure Yes No
  - e) Swelling in your legs or feet (not caused by walking) Yes No
  - f) Heart arrhythmia (heart beating irregularly) Yes No
  - g) High blood pressure Yes No
  - h) Any other heart problem that you've been told about Yes No

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

7. Do you *currently* take medication for any of the following problems?
- a) Breathing or lung problems Yes No
  - b) Heart trouble Yes No
  - c) Blood pressure Yes No
  - d) Seizures (fits) Yes No
- If "yes, name the medications if you know them: \_\_\_\_\_

8. If you have used a respirator, have you *ever had* any of the following problems? (If you have never used a respirator, check the following space and go to question 9) \_\_\_\_\_
- a) Eye irritation Yes No
  - b) Skin allergies or rashes Yes No
  - c) Anxiety Yes No
  - d) General weakness or fatigue Yes No
  - e) Any other problem that interferes with your use of a respirator Yes No

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

---

**ASSESSMENT – TO BE COMPLETED BY A NURSE OR PHYSICIAN IN EMPLOYEE HEALTH SERVICES**

\_\_\_\_\_ Employee is cleared to perform job duties with use of a respirator  
 \_\_\_\_\_ Employee needs an appointment with Employee Health Services for further evaluation  
 \_\_\_\_\_ Other recommendations: \_\_\_\_\_

Employee Health RN/NP/MD Signature \_\_\_\_\_ Date \_\_\_\_\_