

N95 RESPIRATOR USER INITIAL QUESTIONNAIRE

(USE THIS FORM FOR N95 USE IN COMPLIANCE WITH Cal/OSHA SECTION 5199 AEROSOL TRANSMISSABLE DISEASE STANDARD ONLY)

INSTRUCTIONS: Your supervisor must allow you to answer this questionnaire at a time and place that is convenient to you. To maintain your confidentiality, your PI/HR-A/supervisor must not look at or review your answers. Please deliver, mail, or FAX the completed form to Work Health Solutions, where it will be reviewed by a health care professional and kept in your confidential medical record.

Name (Last, First MI)		Sex (M/F)	Date of Birth	Today's Date
Employee ID#	SUNet ID	E-Mail Address		
Phone # where you can be reached		Best time(s) to contact you at this number		
Supervisor's Name		Supervisor's E-Mail Address		

A. MEDICAL HISTORY *(Employee completes)*

Please explain all 'Yes' answers below.

Yes	No	Have you ever had any of the following conditions?
		Asthma or Reactive Airways Disease
		Chronic Bronchitis or Emphysema
		Pneumonia, Tuberculosis, or Pleurisy
		Allergic reaction that interferes with your breathing
		Pneumothorax or broken ribs
		High blood pressure
		Heart attack or Stroke
		Diabetes (sugar disease)
		Seizures (epilepsy; "fits")
		Cancer

Yes	No	Do you currently have any of the following symptoms?
		Shortness of breath
		Coughing up phlegm or blood
		Wheezing
		Chest pain or tightness
		Irregular heart beat or arrhythmia
		Trouble smelling odors
		Claustrophobia or anxiety when wearing a respirator

		Any other problem that may interfere with your use of a respirator
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Explain all 'Yes' answers here:

What medications, if any, do you use for problems with your nose, sinuses, throat, lungs, breathing or heart function?

Would you like to speak with a health care professional about any of your answers to this questionnaire? Yes No

The preceding information is true to the best of my knowledge.

Employee's Signature

Date

B. MEDICAL CLEARANCE *(Physician or other Licensed Health Care Provider completes)*

Medical Clearance for use of an N95 respirator in a clinical care setting:

Approved

Approved with restrictions

Denied

Remarks:

Reviewed by:

Clinician Name/Signature

Date

CONFIDENTIAL WHEN COMPLETED