

RESPIRATOR PROGRAM PROCEDURES FOR FACULTY AND STAFF

When employees are potentially exposed to airborne hazards that cannot be eliminated or reduced to safe levels by ventilation or other means, respirators will be required. However, **before assigning a respirator to an employee, supervisors must ensure that the employee has been medically evaluated, trained, and fit-tested** to the respirator they are assigned. All costs incurred by the medical evaluation process and purchase of respiratory protection are the responsibility of the employees' department.

Step 1. Arrange for a Medical Evaluation with CorpCare in South Windsor

(Note: a Medical Evaluation is not necessarily a physical examination. Typically, it will consist of having an employee complete a detailed questionnaire. A physician or other licensed healthcare professional will then review the questionnaire and make a determination based on the answers received and any follow-up medical examinations, as deemed necessary by the reviewing healthcare professional.)

- a. Have employee(s) complete the medical questionnaire (appended to this document). The department business manager must contact CorpCare to request a review of a respirator questionnaire and to arrange for invoicing 860-647-4796. If respirator use is covered by the **Occupational Health & Safety Program for Animal Handlers**, notify William (Bill) Field at EHS, 860-486-1376, rather than contacting CorpCare for invoicing.
 - i. For privacy purposes, direct employee(s) to put questionnaire in an envelope, seal completely and mark '**CONFIDENTIAL.**'
 - ii. Send sealed envelopes to:
CorpCare, 2800 Tamarack Ave Suite 001
South Windsor, CT 06074

Step 2. Upon receipt of the Written Medical Approval signed form from physician, register for Respiratory Protection Initial (Medical Required) classroom training for new respirator users through [HuskySMS](#) or take refresher training through [HuskySMS](#). Online and classroom modalities are available.

Step 3. After successful completion of training, respirator fit testing can be scheduled. Go to [Respiratory Protection Fit Testing \(Medical Required\)](#) in HuskySMS to arrange. New respirator users will receive fit testing as part of the Respiratory Protection Initial classroom training.

Fit testing cannot occur without EHS receipt of a copy of the written medical approval and documentation of current training.

For more information, refer to the University's [Respirator Program](#), or contact Environmental Health and Safety at 860-486-3613.

Medical Questionnaire: Annual Respirator Clearance Review

TO THE EMPLOYEE:

Can you read? 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) Every employee who has been selected to use any type of respirator must provide the following information.

1. Today's date:

2a. Your full name: SIGNATURE:

2b. Home address:

3a. Your birthdate: 3b. Your age (to nearest year):

4. Gender: Male Female

5. Your height: ft. in. 6. Your weight: lbs.

7a. Your job title:

7b. Your Dept. Name: 7c. Your Unit#:

7d. Supervisor Name: 7e. Supervisor Unit#:

8. A phone number where the health care professional who reviews this questionnaire can reach you:

9. The best time to phone you at this number:

10. **Has your employer told you how to contact the health care professional who will review this questionnaire?**

Yes No

11. Check the type of respirator you will use (you can check more than one category):

a. N, R, or P disposable respirator (filter-mask, non-cartridge type only).

b. Other types (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

If "Other", select all that applies:

½ Face | Full-Face | Loose Fitting Hood | PAPR | Supplied-Air | Self-Contained Breathing Apparatus

12. Have you worn a respirator? 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 select yes or no).

#	Question	Yes	No
1	Do you currently smoke tobacco, or have you smoked tobacco in the last month	<input type="checkbox"/>	<input type="checkbox"/>
2	Have you ever had any of the following conditions?		
a	Seizures (fits)	<input type="checkbox"/>	<input type="checkbox"/>
b	Diabetes (sugar disease)	<input type="checkbox"/>	<input type="checkbox"/>
c	Allergic reactions that interfere with your breathing	<input type="checkbox"/>	<input type="checkbox"/>
d	Claustrophobia (fear of closed-in places)	<input type="checkbox"/>	<input type="checkbox"/>
e	Trouble smelling odors	<input type="checkbox"/>	<input type="checkbox"/>
3	Have you ever had any of the following pulmonary or lung problems?	Yes	No
a	Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>
b	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
c	Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
d	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
e	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
f	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
g	Silicosis	<input type="checkbox"/>	<input type="checkbox"/>
h	Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>
i	Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>
j	Broken ribs	<input type="checkbox"/>	<input type="checkbox"/>
k	Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/>
l	Any other lung problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>
4	Do you currently have any of the following symptoms of pulmonary or lung illness?	Yes	No
a	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
b	Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/>	<input type="checkbox"/>
c	Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
d	Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
e	Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>
f	Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
g	Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>
h	Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>
i	Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/>
j	Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/>
k	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
l	Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
m	Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/>
n	Any other symptoms that you think may be related to lung problems	<input type="checkbox"/>	<input type="checkbox"/>
5	Have you ever had any of the following cardiovascular or heart problems?	Yes	No
a	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
b	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
c	Angina	<input type="checkbox"/>	<input type="checkbox"/>
d	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
e	Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/>	<input type="checkbox"/>
f	Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/>	<input type="checkbox"/>
g	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
h	Any other heart problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>
6	Have you ever had any of the following cardiovascular or heart symptoms?	Yes	No
a	Frequent pain or tightness in your chest	<input type="checkbox"/>	<input type="checkbox"/>
b	Pain or tightness in your chest during physical activity	<input type="checkbox"/>	<input type="checkbox"/>
c	Pain or tightness in your chest that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
d	In the past two years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/>	<input type="checkbox"/>
e	Heartburn or indigestion that is not related to eating	<input type="checkbox"/>	<input type="checkbox"/>
f	Any other symptoms that you think may be related to heart or circulation problems	<input type="checkbox"/>	<input type="checkbox"/>
7	Do you currently take medication for any of the following problems?	Yes	No
a	Breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
b	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
c	Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
d	Seizures (fits)	<input type="checkbox"/>	<input type="checkbox"/>

8	If you have used a respirator, have you ever had any of the following problems?	Yes	No
*	If you've never used a respirator, check here and go to question 9		
a	Eye irritation	<input type="checkbox"/>	<input type="checkbox"/>
b	Skin allergies or rashes	<input type="checkbox"/>	<input type="checkbox"/>
c	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
d	General weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>
e	Any other problem that interferes with your use of a respirator	<input type="checkbox"/>	<input type="checkbox"/>
9	Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	<input type="checkbox"/>	<input type="checkbox"/>
10	Have you ever lost vision in either eye (temporarily or permanently)?	<input type="checkbox"/>	<input type="checkbox"/>
11	Do you currently have any of the following vision problems?	Yes	No
a	Wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
b	Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>
c	Color blind	<input type="checkbox"/>	<input type="checkbox"/>
d	Any other eye or vision problem	<input type="checkbox"/>	<input type="checkbox"/>
12	Have you ever had an injury to your ears, including a broken eardrum?	<input type="checkbox"/>	<input type="checkbox"/>
13	Do you currently have any of the following hearing problems?	Yes	No
a	Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>
b	Wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>
c	Any other hearing or ear problem	<input type="checkbox"/>	<input type="checkbox"/>
14	Have you ever had a back injury?	<input type="checkbox"/>	<input type="checkbox"/>
15	Do you currently have any of the following musculoskeletal problems?	Yes	No
a	Weakness in any of your arms, hands, legs, or feet	<input type="checkbox"/>	<input type="checkbox"/>
b	Back pain	<input type="checkbox"/>	<input type="checkbox"/>
c	Difficulty fully moving your arms and legs	<input type="checkbox"/>	<input type="checkbox"/>
d	Pain or stiffness when you lean forward or backward at the waist	<input type="checkbox"/>	<input type="checkbox"/>
e	Difficulty fully moving your head up or down	<input type="checkbox"/>	<input type="checkbox"/>
f	Difficulty fully moving your head side to side	<input type="checkbox"/>	<input type="checkbox"/>
g	Difficulty bending at your knees	<input type="checkbox"/>	<input type="checkbox"/>
h	Difficulty squatting to the ground	<input type="checkbox"/>	<input type="checkbox"/>
i	Climbing a flight of stairs or a ladder carrying more than 25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>
j	Any other muscle or skeletal problem that interferes with using a respirator	<input type="checkbox"/>	<input type="checkbox"/>
16	How often are you expected to use the respirator(s)? Select yes or no for all answers that apply to you.	Yes	No
a	Escape only (no rescue)	<input type="checkbox"/>	<input type="checkbox"/>
b	Emergency rescue only	<input type="checkbox"/>	<input type="checkbox"/>
c	Less than 5 hours per week	<input type="checkbox"/>	<input type="checkbox"/>
d	Less than 2 hours per day	<input type="checkbox"/>	<input type="checkbox"/>
e	2 to 4 hours per day	<input type="checkbox"/>	<input type="checkbox"/>
f	Over 4 hours per day	<input type="checkbox"/>	<input type="checkbox"/>
17	During the period you are using the respirator(s), is your work effort	Yes	No
a	Light (less than 200 kcal per hour)	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, how long does this period last during the average shift: hrs. mins		
Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1–3 lbs.) or controlling machines.			
b	Moderate (200 to 350 kcal per hour)	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, how long does this period last during the average shift: hrs. mins.		
Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.			
c	Heavy (above 350 kcal per hour)	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, how long does this period last during the average shift: hrs. mins.		
Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).			
18	Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator? If yes, describe this protective clothing and/or equipment:	<input type="checkbox"/>	<input type="checkbox"/>
19	Will you be working under hot conditions (temperature exceeding 77°F)?	<input type="checkbox"/>	<input type="checkbox"/>
20	Will you be working under humid conditions?	<input type="checkbox"/>	<input type="checkbox"/>