

Date: _____

Dear:

Your Fire Department physical is scheduled for: ____/____/____ @ _____

Prior to your physical you will need to:

- Complete all enclosed forms.
- Have your Chief or authorized personnel complete your authorization form.
- If under 18, have your parent or guardian sign your parental consent form.

For the day of your physical you will need to:

- **Fast** at least 8 hours for your blood work. Water is allowed, and take any scheduled medications.
- **Complete Hemacult** and bring with you, instruction sheet is in the packet.
- Make sure you are **clean shaven** for your Fit Test. Bring personal mask if you have one.
- Wear **comfortable clothes and shoes for Stress Test** if applicable.
- **Females**-you will need a copy of your most recent well woman check-up and mammogram.

All pending information must be provided to Carroll Occupational Health or Frederick Health Employer Solutions within 2 weeks of the date of your physical or you will not be qualified.

Please do not hesitate to contact me with any questions. We look forward to your visit and appreciate your dedication to our community.

Sincerely,

Lisa Degitz
Practice Manager

AUTHORIZATION FOR MEDICAL SERVICES MUST BE PRESENTED AT TIME OF SERVICE

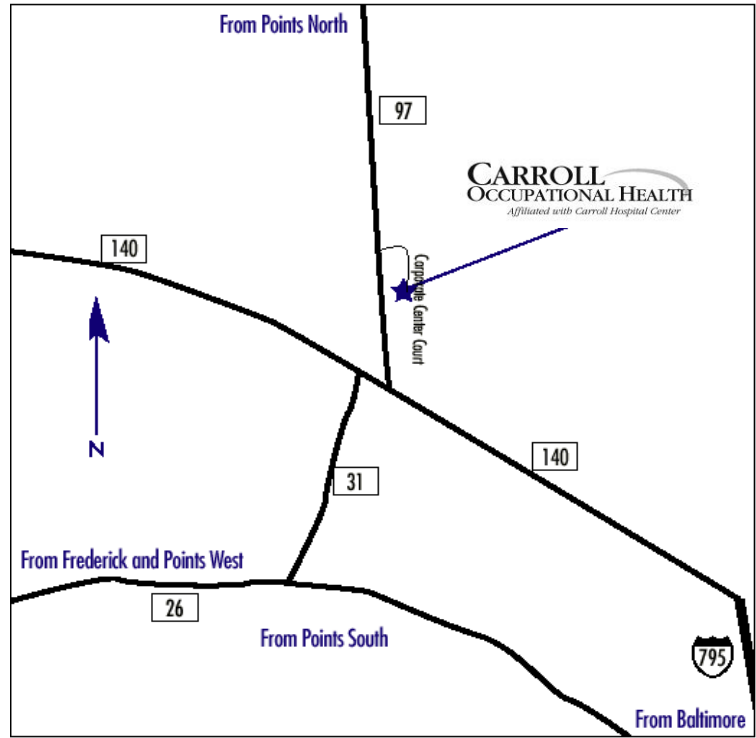
COMPANY NAME			CC Volunteer Emer. Svc. Assoc		
NAME OF STATION			EMPLOYEE'S NAME		
I authorize to you to provide this employee with the medical attention indicated below. I further acknowledge my company's responsibility for the payment of services.					
AUTHORIZED BY (SIGNATURE)			DATE SIGNED	PRINTED NAME	
TITLE			PHONE NO.		
<input type="checkbox"/> Work-Related Injury		Date of Injury: _____		<input type="checkbox"/> Paid <input type="checkbox"/> Volunteer	
What Station was employee working/volunteering at when Injury occurred? _____					
<input type="checkbox"/> ATR <input type="checkbox"/> HazMat <input type="checkbox"/> Fire Police <input type="checkbox"/> Dive Team <input type="checkbox"/> Driver				<input type="checkbox"/> Approved for Saturday Appt.	
PHYSICAL EXAMS			Check examination requested.		
_____ Initial Emergency Responder Physical					
_____ Annual Emergency Responder Physical					
_____ Fitness-For-Duty					
_____ Return-to-Work Urine Drug Screen 5 Panel Non-DOT					
_____ Requires DOT Physical					

Carroll Occupational Health
 700-B Corporate Center Court, Suite A
 Westminster, MD 21157
Appointments: 410-871-0470
Fax: 410-871-0743

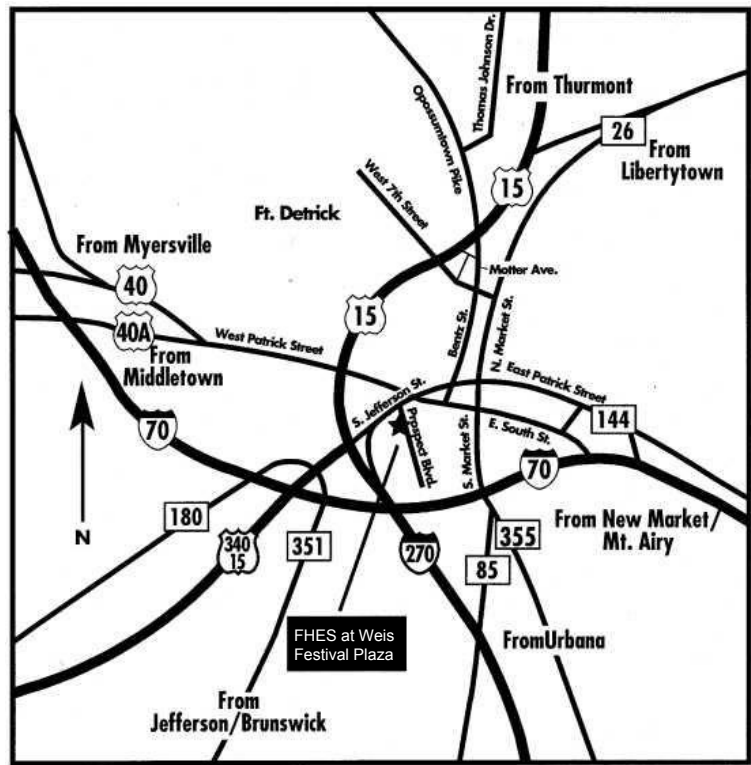
Frederick Health Employer Solutions
 490-L Prospect Blvd
 Fredeick, MD 21701
Appointments: 240-566-3001
Fax: 240-566-3003

Hours: Monday – Friday – 7:00am – 5:00pm

Carroll Occupational Health:



Frederick Health Employer Solutions:



Patient Name: _____ Company: _____ Date: _____

Company Contact: _____

Birthdate: ___/___/___ Age ___

Medical History - Comprehensive

Allergies: Latex: _____ Yes _____ No

Medication Allergies: _____

Other Allergies: _____

Last Tetanus booster: _____

Current Medications: _____

Current Physician: _____

Medical Illnesses - check all that apply:

___ High Blood Pressure

___ Heart Disease

___ Lung Disease

___ Kidney Disease

___ Diabetes

___ Anemia

___ Seizures

___ Cancer

___ Stomach or Bowel Disorders: _____

___ Sleep Apnea

___ Fractures & Joint Injuries: _____

___ Other: _____

Surgeries: _____

Social History - Check all that apply :

___ Tobacco use ___ Cigarettes: ___ packs/day ___ years

 ___ Cigars: ___ per day ___ years

 ___ Pipe: ___ years

 ___ Chew/Snuff: ___ years

___ Alcohol use ___ Drinks per week

Place an X in the box if you have any of the conditions below now or in the past:
(Caregivers: please comment on positive responses):

Vision (Vision)

___ 1. Do you use glasses?:

Heart/Vascular

___ For reading

Do you have:

___ For distant vision

___ 16. Chest pain on effort

___ Contacts

___ 17. High blood pressure

___ 2. Are you color blind?

___ 18. Shortness of breath

___ 19. Swelling of ankles

___ 20. Heart murmur

3. Do you have:

Have you had:

___ Retinal disease

___ 21. Heart attack

___ Cataracts

___ 22. Stroke

___ Glaucoma

___ 23. Rheumatic fever

___ 4. Do you use eye medicine?

___ 24. Heart failure

___ 5. Have you had eye surgery?

___ 25. Heart surgery/Stent/Pacemaker

___ 6. Have you had laser exposure?

Hearing

Do you have

- 7. Difficulty hearing
- 8. Ear disease
- 9. Ringing in the ears
- 10. Abnormal hearing test
- 11. Do you use a hearing aid?
- 12. Have you had ear surgery?
- 13. Ruptured ear drum?
- 14. Exposure to gunfire?
- 15. Wear hearing protection?

Liver or Gastrointestinal

Do you have or have you had:

- 37. Hepatitis
- 38. Cirrhosis
- 39. Jaundice
- 40. Frequent indigestion
- 41. Ulcer disease
- 42. Colitis
- 43. Other intestinal problems
- 44. Do you have a hernia?
- 45. Have you had hernia surgery?

Genitourinary:

Do you or have you had:

- 46. Kidney trouble
- 47. Bladder trouble
- 48. Kidney stones

Skin:

- 49. Do you have eczema?
- 50. Do you have psoriasis?
- 51. Any other skin conditions

Neurologic

- 52. Tremors
- 53. Dizzy spells
- 54. Convulsions
- 56. Nerve damage
- 57. Serious head injury
- 58. Brain surgery
- 59. Nervous breakdown

Are you taking medication for:

- 60. Anxiety or depression
- 61. Epilepsy
- 62. Parkinson's disease

Respiratory

Do you have:

- 26. Chronic cough
- 27. Asthma
- 28. Bronchitis
- 29. Hay fever
- 30. Emphysema/COPD

Have you had:

- 31. Tuberculosis
- 32. Lung cancer
- 33. Lung surgery
- 34. Silicosis
- 35. Asbestos
- 36. Black lung

Blood, Endocrine

Have you had:

- 63. Anemia
- 64. Bleeding problems
- 65. Hormone problems
- 66. Diabetes
- 67. Thyroid problem

Musculoskeletal:

Do you or have you had:

- 68. Back trouble
- 69. Disc problems/surgery
- 70. Shoulder problems/surgery
- 71. Arm problems/surgery
- 72. Wrist problems/surgery
- 73. Hand problems/surgery
- 74. Hip problems/surgery
- 75. Leg problems/surgery
- 76. Knee problems/surgery
- 77. Ankle problems/surgery
- 78. Foot problems/surgery
- 79. Broken bones
- 80. Numbness, tingling, and/or pain in hands or arms

Communicable Diseases:

Have you had:

- 81. Chicken pox
- 82. Measles
- 83. German Measles
- 84. Mumps
- 85. Hepatitis A
- 86. Hepatitis B
- 87. Hepatitis C

Please list all prior jobs:

Company Name:	Dates Employed:	Job Description:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle any of the following processes and/or jobs done in the past:

Processes: abrasive blasting acid/alkali treatment
 degreasing electroplating
 foundry forging
 painting welding
 grinding or metal machining

Industries: flour, feed or grain cotton processing
 rubber insulation
 quarry work construction
 farming petroleum
 shipyards

Circle any of the following substances to which you have had regular exposure in the workplace:

Fumes or dusts:
 silica coal asbestos talc
 fiberglass cotton dust sawdust
 other: _____

Solvents:
 benzene carbon tetrachloride trichloroethylene
 naptha xylene other : _____

Chemicals or gases :
 ammonia formaldehyde hydrogen sulfide
 cyanide sulfur dioxide chromium
 mercury lead cadmium
 nickel other: _____

Miscellaneous:
 radiation insecticides/herbicides
 cutting oils motor exhaust
 noise

Have you ever needed medical care for exposure to any of the above?
 ___ Yes ___ No

Type of problem: Skin: _____ Lungs: _____ Other: _____

Work related injuries and illnesses:

Year:	Injury and treatment:	Time off work:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes No Explain if yes
 ___ ___ Have you ever applied for worker's compensation or disability payments for any injury or illness which developed on the job? Explain:

Are you currently being treated by a doctor for a work related injury or illness? Explain:

Employee Signature

Date

Reviewed By

Date

f-hxcomp

Patient Name: _____ Company: _____ Date: _____

Company Contact: _____

Birthdate: ___/___/___ Age ___

AUDIO HISTORY FORM

Department: _____ Shift: _____ Job Title: _____
Sex: _____ Male _____ Female

Type of Test: (Circle One) PREPLACEMENT BASELINE (Initial) ANNUAL
RETEST TERMINATION OTHER

Have you been exposed to noise within the last 14 hours? [] Yes [] No
Explain: _____

How do you rate your hearing?
[] Unknown [] Very poor [] Average [] Good [] Very good

Hearing protection, Do you wear while at work?
[] Not used [] Seldom used [] Sometime used
[] ½ time [] Usually used [] Always used
If yes, what type of hearing protection do you wear?

[] Earplugs [] Earmuffs [] Both Brand: _____

MEDICAL HISTORY: (Check the correct answer)

- | | | | |
|--|----------------|--|----------------|
| 10. Ear pain | [] Yes [] No | 25. Scarlet Fever | [] Yes [] No |
| 11. Draining Ear | [] Yes [] No | 26. Measles | [] Yes [] No |
| 12. Dizziness/imbalance | [] Yes [] No | 27. Meningitis | [] Yes [] No |
| 13. Severe ringing | [] Yes [] No | 28. Diabetes | [] Yes [] No |
| 14. Sudden hearing loss | [] Yes [] No | 29. Kidney disease | [] Yes [] No |
| 15. Fluctuating hearing loss | [] Yes [] No | 30. Visible wax/objects | [] Yes [] No |
| 16. Fullness/discomfort | [] Yes [] No | 31. Allergies | [] Yes [] No |
| 17. History of prior Disease/ear problem | [] Yes [] No | 32. Family hearing loss | [] Yes [] No |
| 18. Recent prescription Drugs | [] Yes [] No | 33. High noise exposure today | [] Yes [] No |
| 19. High blood pressure | [] Yes [] No | 34. History of prior ear disease before test | [] Yes [] No |
| 20. See MD for ears | [] Yes [] No | 35. Head cold today | [] Yes [] No |
| 21. Ear surgery | [] Yes [] No | 36. Military service | [] Yes [] No |
| 22. Unconsciousness | [] Yes [] No | 37. Noisy hobbies | [] Yes [] No |
| 23. Wear hearing aid | [] Yes [] No | 38. Loud music/headphones | [] Yes [] No |
| 24. Mumps | [] Yes [] No | 39. Firearms/guns | [] Yes [] No |

Explain any "yes" answers: _____

MEDICATIONS (Past and Present) (Please check appropriate boxes)

- [] Aspirin, Buffered, Exedrin (more than 6/day)
 [] Neomycin [] Streptomycin [] Gentamycin [] Quinine

Explain any checked answers: _____

Signature _____ Date _____

OTOSCOPIC EXAM:

Right [] Normal [] Abnormal _____ Examiners Initials _____
Left [] Normal [] Abnormal _____ Examiners Initials _____

Patient Name: _____ Company: _____ Date: _____

Company Contact: _____

Birthdate: ___/___/___ Age ___

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

- 0 = no chance of dozing
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total Score:	_____

Patient Signature: _____

Caregiver Signature: _____

f-epwort

OSHA Mandatory Respirator Medical Evaluation Questionnaire
29 CFR 1910.134

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A do not require a medical examination.

To the employee: Can you read: yes no

Your employer must allow you to answer the questionnaire during normal working hours, or at a time 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

1. Today's Date ____/____/____	2. Your Name	3. Your Age
4. Leave Blank	5. Your Job Title	6. Your Date of Birth
7. Sex (circle one) Male Female	8. Your Height _____ Ft. _____ in.	9. Your Weight _____ Lbs.
10. Phone # where you can be reached to discuss your answers: (____) _____ - _____	11. The best time to call you at this number: _____ a.m. p.m.	

12. Has your employer told you how to contact the health care professional who will review this questionnaire? yes no

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

14. 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.

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) <input type="checkbox"/> yes <input type="checkbox"/> no	b. Diabetes (sugar disease): <input type="checkbox"/> yes <input type="checkbox"/> no	c. Trouble smelling odors: <input type="checkbox"/> yes <input type="checkbox"/> no
d. Claustrophobia (fear of closed-in places) <input type="checkbox"/> yes <input type="checkbox"/> no	e. Allergic reaction that interfere with your breathing? <input type="checkbox"/> yes <input type="checkbox"/> no	

3. Have you *ever had* any of the following pulmonary or lung problems?

a. Asbestosis <input type="checkbox"/> yes <input type="checkbox"/> no	b. Asthma <input type="checkbox"/> yes <input type="checkbox"/> no	c. Chronic bronchitis <input type="checkbox"/> yes <input type="checkbox"/> no
d. Emphysema <input type="checkbox"/> yes <input type="checkbox"/> no	e. Pneumonia <input type="checkbox"/> yes <input type="checkbox"/> no	f. Tuberculosis <input type="checkbox"/> yes <input type="checkbox"/> no
g. Silicosis <input type="checkbox"/> yes <input type="checkbox"/> no	h. Pneumothorax (collapsed lung) <input type="checkbox"/> yes <input type="checkbox"/> no	i. Lung cancer <input type="checkbox"/> yes <input type="checkbox"/> no
j. Broken ribs <input type="checkbox"/> yes <input type="checkbox"/> no	k. Any chest injuries or surgeries <input type="checkbox"/> yes <input type="checkbox"/> no	l. Any other lung problem you've been told about <input type="checkbox"/> yes <input type="checkbox"/> no

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 <input type="checkbox"/> yes <input type="checkbox"/> no	b. Stroke: <input type="checkbox"/> yes <input type="checkbox"/> no
c. Angina <input type="checkbox"/> yes <input type="checkbox"/> no	d. Swelling in your legs and feet (not caused by walking) <input type="checkbox"/> yes <input type="checkbox"/> no
e. Heart Failure <input type="checkbox"/> yes <input type="checkbox"/> no	f. Heart arrhythmia (irregular heart beat) <input type="checkbox"/> yes <input type="checkbox"/> no
g. High blood pressure <input type="checkbox"/> yes <input type="checkbox"/> no	h. Any other heart problem that you've been told about: <input type="checkbox"/> yes <input type="checkbox"/> no

6. Have you *ever had* any of the following cardiovascular or heart symptoms?
- a. Frequent pain or tightness in the 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 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?

Breathing problems <input type="checkbox"/> yes <input type="checkbox"/> no	Heart trouble <input type="checkbox"/> yes <input type="checkbox"/> no	Blood Pressure <input type="checkbox"/> yes <input type="checkbox"/> no	Seizures (fits) <input type="checkbox"/> yes <input type="checkbox"/> no
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8. If you've used a respirator, have you *ever had* any of the following problems? (if you've never used a respirator, check

the following box and go to question 9.

a. Eye Irritation: <input type="checkbox"/> yes <input type="checkbox"/> no	b. Skin allergies or rashes: <input type="checkbox"/> yes <input type="checkbox"/> no
c. Anxiety <input type="checkbox"/> yes <input type="checkbox"/> no	d. General weakness or fatigue: <input type="checkbox"/> yes <input type="checkbox"/> 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 your answers to this questionnaire: yes no

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you *ever-lost* vision in either eye (temporarily or permanently): yes no

11. Do you *currently* have any of the following vision problems:

a. Wear contact lenses: <input type="checkbox"/> yes <input type="checkbox"/> no	b. Wear glasses: <input type="checkbox"/> yes <input type="checkbox"/> no
c. Color blind: <input type="checkbox"/> yes <input type="checkbox"/> no	d. Any other eye or vision problem: <input type="checkbox"/> yes <input type="checkbox"/> no

12. Have you *ever had* an injury to you ears, including a broken eardrum: yes no

13. Do you *currently* have any of the following hearing problems?

- a. Difficulty hearing: yes no
- b. Wear a hearing aid: yes no
- c. Any other hearing or ear problem: yes no

14. Have you *ever had* a back injury: yes no

15. Do you *currently* have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs or feet: <input type="checkbox"/> yes <input type="checkbox"/> no	b. Back pain <input type="checkbox"/> yes <input type="checkbox"/> no
c. Difficulty fully moving you arms & legs: <input type="checkbox"/> yes <input type="checkbox"/> no	d. Pain or stiffness when you lean forward or backward at the waist: <input type="checkbox"/> yes <input type="checkbox"/> no
e. Difficulty fully moving your head up or down: <input type="checkbox"/> yes <input type="checkbox"/> no	f. Difficulty fully moving your head side to side: <input type="checkbox"/> yes <input type="checkbox"/> no
g. Difficulty bending at your knees: <input type="checkbox"/> yes <input type="checkbox"/> no	h. Difficulty squatting to the ground: <input type="checkbox"/> yes <input type="checkbox"/> no
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.: <input type="checkbox"/> yes <input type="checkbox"/> no	j. Any other muscle or skeletal problem that interferes with using a respirator: <input type="checkbox"/> yes <input type="checkbox"/> no

Part B

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health

care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 ft) or in a place that has lower than normal amounts of oxygen: yes no

If “yes” do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you’re working under these conditions: yes no

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: yes no

If “yes” name the chemicals if you know them:

3. Have you ever worked with any of the materials, or under any of the conditions listed below:

a. Asbestos: <input type="checkbox"/> yes <input type="checkbox"/> no	b. Silica: <input type="checkbox"/> yes <input type="checkbox"/> no	c. Tungsten/Cobalt: <input type="checkbox"/> yes <input type="checkbox"/> no
d. Beryllium: <input type="checkbox"/> yes <input type="checkbox"/> no	e. Aluminum <input type="checkbox"/> yes <input type="checkbox"/> no	f. Coal: <input type="checkbox"/> yes <input type="checkbox"/> no
g. Iron: <input type="checkbox"/> yes <input type="checkbox"/> no	h. Tin: <input type="checkbox"/> yes <input type="checkbox"/> no	i. Dusty environments: <input type="checkbox"/> yes <input type="checkbox"/> no

j. Any other hazardous exposures: <input type="checkbox"/> yes <input type="checkbox"/> no
If “yes” describe the exposure:

4. List any second jobs or side businesses you have:

5. List your previous occupations:

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6. List your current & previous hobbies:

7. Have you been in the military service? yes no

If "yes" describe these exposures:

8. Have you ever worked on a HAZMAT team? yes no

9. Other than the medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications):

yes no

If "yes" name the medications if you know them:

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters <input type="checkbox"/> yes <input type="checkbox"/> no	b. Canisters (e.g. gas masks) <input type="checkbox"/> yes <input type="checkbox"/> no	c. Cartridges <input type="checkbox"/> yes <input type="checkbox"/> no
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11. How often are you expected to use the respirator:

a. Escape only; no rescue <input type="checkbox"/> yes <input type="checkbox"/> no	b. Emergency rescue only <input type="checkbox"/> yes <input type="checkbox"/> no
c. Less than 5 hours per week <input type="checkbox"/> yes <input type="checkbox"/> no	d. Less than 2 hours per day <input type="checkbox"/> yes <input type="checkbox"/> no
e. 2 to 4 hours per day <input type="checkbox"/> yes <input type="checkbox"/> no	f. Over 4 hours per day <input type="checkbox"/> yes <input type="checkbox"/> no

12. During the period you are using the respirator(s), is your work effort:

a. *Light* (less than 200 kcal per hour): yes no

If "yes", how long does this period last during the average shift

_____ hours _____ minutes

Examples of a light work effort are <i>sitting</i> while writing, typing, drafting, or performing light assembly work; or <i>standing</i> while operating a drill press (1-3 lbs.) or controlling machines.

b. *Moderate* (200 to 350 kcal per hour) yes no

If "yes", how long does this period last during the average shift

_____ hours _____ minutes

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):

yes no

If "yes", how long does this period last during the average shift
_____ hours _____ minutes

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.)

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using the respirator:

yes no

If "yes" describe this protective clothing and/or equipment:

14 Will you be working under hot conditions (temperature exceeding 77 degrees F)

yes no

15. Will you be working under humid conditions:

yes no

16. Describe the work you'll be doing while you're using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (e.g., confined spaces, life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s)

Name of toxic substance - #1
Estimated maximum exposure level per shift
Duration of exposure per shift:

Name of toxic substance - #2
Estimated maximum exposure level per shift
Duration of exposure per shift

Name of toxic substance - #3
Estimated maximum exposure level per shift

Duration of exposure per shift

Name of toxic substance - #4

Estimated maximum exposure level per shift

Duration of exposure per shift

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well being of others (e.g. rescue, security)

Employee Signature

Date

OSHA Mandatory Respirator Medical Evaluation Questionnaire Reviewed by:

Healthcare Provider Signature

Date