University of Windsor

OHS 4.5.8a University of Windsor Respirator User Screening Form

Name: _____ **Occupation / Title:** _____

Employee #: _____ **Department:** _____ **Supervisor:** _____

Activities requiring respirator use: _____

Avg. frequency of respirator use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other: _____

Please complete this form prior to respirator fit testing.

PART A RESPIRATOR USER'S HEALTH CONDITIONS

1. **Check "Yes" or "No" boxes only. DO NOT specify conditions. Medical information is NOT to be offered on this form.**
   a) Some conditions can seriously affect your ability to safely use a respirator. Do you have or do you experience any of the following, or another condition which may affect respirator use? ☐ **YES** ☐ **NO**

Shortness of breath	Breathing difficulties	Chronic bronchitis	Emphysema
Lung disease	Chest pain on exertion	Heart problems	Allergies
Hypertension	Cardiovascular disease	Thyroid problems	Diabetes
Neuromuscular disease	Fainting spells	Dizziness/nausea	Seizures
Temperature susceptibility	Claustrophobia/fear of heights	Hearing impairment	Dentures
Panic attacks		Asthma	Pacemaker
Vision impairment w/o correction	Colour blindness	Reduced sense of taste	Other condition(s) affecting respirator use
Back/neck problems	Reduced sense of smell		
	Unusual facial features/skin conditions		Prescription medication to control a condition

*** Note medical information is not to be offered on this form ***

b) Have you had previous difficulty while using a respirator? ☐ **YES** ☐ **NO**

c) Do you have any concerns about your future ability to use a respirator safely? ☐ **YES** ☐ **NO**

If **"YES"** was answered to questions a), b) or c), further assessment by a health care professional is required prior to respirator use. Please complete **PART B Health Care Professional Primary Assessment** on next page.

Signature of Respirator User: _____ **Date:** _____

Office of Health & Safety use only

Employee is fit for respirator use: ☐ YES ☐ NO Type of Fit Test: ☐ QLFT ☐ QNFT

Respirator Type: Make:_____ Model: _____

☐ Filtering Face Piece ☐ Half Mask ☐ Full Face Piece

Fit Tested by: _____ **Date:** _____

Recertification Date (2 years): _____

For additional respirators please attach a separate sheet

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PART B HEALTH CARE PROFESSIONAL PRIMARY ASSESSMENT (if required)

Assessment date: _____

Respirator use permitted: ☐ YES ☐ NO

Referred to medical assessment: ☐ YES ☐ NO

Comments: _____

_____

Reassessment date: _____

Name of Health Care Professional (print): _____ **Signature of HCP:** _____

PART C MEDICAL ASSESSMENT (if required)

Assessment date: _____

☐ **Class 1. No Restrictions**

☐ **Class 2. Some specific Restrictions apply (specify):** _____

☐ **Class 3. Respirator use is NOT permitted**

Name of Physician (print): _____ **Signature of Physician:** _____