University of Lethbridge

UNIVERSITY OF LETHBRIDGE RESPIRATOR USER SCREENING FORM

(For initial and periodic screening of respirator users in conjunction with CSA Z94.4, Clause 12)

PART 1: EMPLOYER INFORMATION

Supervisor name: _____ Email & Telephone: ( ) _____

PART 2: RESPIRATOR USER INFORMATION

Name & Employee #: _____ Email: _____

Title/Occupation: _____ Telephone: ( ) _____

PART 3: CONDITIONS OF USE

ACTIVITIES requiring respirator use: _____

FREQUENCY of respirator use: ❑ Daily ❑ Weekly❑ Monthly❑ Yearly❑ Other

EXERTION level during use: ❑ Light ❑ Moderate❑ Heavy❑ Other DURATION of respirator use per shift: ❑ < 1/4 h ❑ > 1/4 h ❑ > 2 h ❑ Variable❑ Other

TEMPERATURE during use: ❑ < 0° C ❑ > 0 and < 25° C ❑ > 25° C ATMOSPHERIC PRESSURE during use: ❑ Reduced ❑ Normal/ambient ❑ Increased

SPECIAL WORK CONSIDERATIONS

Uncontrolled hostile environment:

❑ Emergency escape ❑ Rescue operations ❑ IDLH

❑ Hazardous materials (emergency) ❑ Oxygen deficiency ❑ Confined spaces

❑ Other

Other personal protective equipment:

❑ Additional types of personal protective equipment required (specify): _____

❑ Estimated total weight of tools/equipment carried during respirator use: _____

PART 4: TYPES OF RESPIRATORS USED (check all that apply)

❑ Tight-fitting (N-95, half or full face) ❑ Non-tight-fitting (e.g., hood) ❑ SCBA — open-circuit

❑ Mouth bit ❑ SCBA — closed-circuit ❑ Air-purifying, non-powered ❑ Airline, continuous-flow

❑ SCBA — escape

PART 5: RESPIRATOR USER'S HEALTH CONDITIONS

Check Yes or No box only. DO NOT SPECIFY - this is a list of things which might possible affect you but *Medical information is NOT to be offered on this form.*

Some conditions can seriously affect your ability to safely use a respirator.

a) Do you have or do you experience any of the following or any other condition that could 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 Pacemaker Panic attacks

Colour blindness Asthma Vision impairment Reduced sense of smell

Reduced sense of taste Back/Neck problems Unusual facial features/Skin conditions

Dentures Prescription medication to control a condition

Other condition(s) affecting respirator use:

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**

A "YES" answer to (a), (b), or (c) indicates further assessment by a health care professional is required prior to respirator use and you will be contacted for this assessment.

Signature of respirator user: _____

Supervisor's initials: _____

Date: 26-Apr-2018

PART 6: HEALTH CARE PROFESSIONAL PRIMARY ASSESSMENT (if required)

Assessment date:

Respirator use permitted:	❑ Yes	❑ No	❑ Uncertain
Referred to medical assessment:	❑ Yes	❑ No	

Reassessment date: _____

Name of health care professional (HCP): Title: _____

Signature of HCP: _____

PART 7: 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: _____

Signature of physician: _____