Screening Form - Respirator Use

Part 1: Employer Information

Employer Name ______________________ Employer # ______________
Supervisor Name ______________________ Date ______________
Worksite Address ______________________ Phone ______________
______________________ Phone/Fax ______________

Part 2: Respirator User Information

Name ______________________ Employee # ______________
Title/Position ______________________ Phone/Fax ______________

Part 3: Conditions of Use

Activities requiring respirator use: ______________________
____

Frequency of respirator use: ☐daily ☐weekly ☐monthly ☐yearly ☐uncertain

Exertion Level during use: ☐light ☐moderate ☐heavy

Duration of respirator use per shift: ☐<1/4 hr ☐>1/4 hr ☐>2 hr ☐variable ☐unknown

Temperature during use: ☐<0°C ☐>0 & <25°C ☐>25°C

Atmospheric pressure during use: ☐reduced ☐normal/ambient ☐increased

Special Work Considerations

Uncontrolled Hostile Environment:

☐Emergency Escape ☐IDLH ☐Confined Spaces

☐Rescue Operations ☐Oxygen Deficiency ☐Hazardous Materials (Emergency)

☐Other ______________________

Other Personal Protective Equipment:

☐Additional types of personal protective equipmentrequired, specifiy: ______________________

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

Maximum: ______________________ Average: ______________________

Part 4: Types of Respirators Used

(Check all that apply)

☐Tight-fitting ☐Non tight-fitting ☐Supplied-air, continuous flow

☐Mouth bit ☐Supplied-air, demand ☐Supplied-air, pressure demand

☐Air-purifying, nonpowered ☐SCBA, open circuit ☐SCBA, escape

☐Air-purifying, powered ☐SCBA, closed circuit ☐SCBA, closed circuit escape

☐Combination pressure demand/supplied air with escape ☐Supplied-air suit

☐Combination supplied-air with air-purifying elements ☐Other ____________________________

Part 5: Respirator User's Health Conditions

(Check YES or NO box only - Do not specify)

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 that may affect respirator use?

☐YES **☐NO** ***DO NOT INDICATE A CONDITION***

Shortness of Breath	Breathing Difficulties	Chronic Bronchitis	Allergies
Lung Disease	Chest pain on exertion	Heart Problems	Diabetes
Hypertension	Cardiovascular Disease	Thyroid Problems	Seizures
Neuromuscular Disease	Fainting Spells	Dizziness/Nausea	Dentures
Temperature Susceptibility	Clautrophobia/Fear of heights	Hearing Impairment	Asthma
Anxiety / Panic Attacks	Colour blindness	Reduced sense of taste	
Vision Impairment	Reduced sense of smell	Emphysema	
Back/neck problems	Facial features/skin conditions	Pacemaker	
Prescription medication	Other condition(s)		

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

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

If you answered YES to one or more questions in Section 5, further assessment by a health care professional is required prior to respirator use. NOTE: Medical information is NOT to be offered on this form.

Signature of Respirator User: ____

Fit Tester's Signature: ____ Date ____________________________