UNIVERSITY OF TORONTO

ENVIRONMENTAL HEALTH & SAFETY

RESPIRATOR USER SCREENING FORM

Parts 1, 2 and 3 of this form to be completed by the supervisor of the respirator user

PART 1: RESPIRATOR USER INFORMATION

First Name: _____ **Last Name:** _____

Personnel Number: _____ **Telephone:** _____

Department: _____ **Job Title:** _____

Supervisor Name: _____

Do you require a respirator (e.g., N95) for a clinical placement at an off-campus location (e.g., hospital)? ☐ Yes ☐ No

Are you an undergraduate dental student who needs a respirator fit test for clinical work? ☐ Yes ☐ No

Please note: If you answered "Yes" to either question, do not proceed with booking an appointment with EHS. You must arrange your fit test with a 3rd-party vendor through your faculty or department. Speak to your faculty/department contact.

PART 2: CONDITIONS OF USE AND SPECIAL WORK CONSIDERATIONS

Activities requiring respirator use: _____

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

Exertion level during use: ☐ light ☐ moderate ☐ heavy ☐ other

Duration of respirator use per shift: ☐ < ¼ hour ☐ > ¼ hour ☐ > 2 hours ☐ variable

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

Conditions pertaining to heat or cold stress:

- ☐ Not applicable
- ☐ Continuous work > 30 minutes when Humidex > 30°C (indoors or outdoors)
- ☐ Continuous work > 30 minutes in hot indoor areas (e.g., steam plant, mechanical rooms)
- ☐ Continuous work > 30 minutes in temperatures < -15°C or wind chill < -25°C

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

Uncontrolled hostile environment: ☐ not applicable ☐ emergency escape ☐ police activity ☐ IDLH

- ☐ oxygen deficiency ☐ confined spaces ☐ hazardous materials (emergency)
- ☐ other (please specify): _____

Other personal protective equipment (PPE):

☐ Not applicable

☐ Additional types of PPE equipment will be worn during respirator use:

Please specify: _____

☐ Tools/equipment will be carried during respirator use:

Maximum weight of tools/equipment: _____ Average weight of tools/equipment: _____

PART 3: TYPES OF RESPIRATORS TO BE USED (check all that apply)

Tight-fitting facepiece respirator

- ☐ Disposable air-purifying respirator (e.g., N95)
- ☐ Non-powered half-face elastomeric respirator
- ☐ Non-powered full-face elastomeric respirator
- ☐ Powered air-purifying respirator (PAPR)
- ☐ **Supplied-air respirator (SAR)**
- ☐ **Self-contained breathing apparatus (SCBA)**

Loose-fitting facepiece respirator

- ☐ PAPR with hood or headcover
- ☐ SAR with hood or headcover
- ☐ **Supplied-air suit**
- ☐ **Other (specify):** _____

Please note: EHS conducts fit-testing with a limited number of respirator options. If a department uses a specific make and model of respirator, the user is responsible for bringing a respirator to the fit-testing session. Please contact EHS if you have any questions.

Supervisor Signature: _____ **Date:** _____

PART 4: RESPIRATOR USER'S HEALTH CONDITIONS (to be completed by respirator user)

(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 any other condition that could affect respirator use? Check YES or NO. **DO NOT specify the condition(s).**

☐ **YES** ☐ **NO**

Shortness of breath	Breathing difficulties	Chronic bronchitis	Emphysema
Lung disease	Chest pain or 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
Reduced sense of smell	Reduced sense of taste	Vision impairment	Back/neck problems
Facial features/skin conditions			
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 concerns about your future ability to use a respirator safely? ☐ **Yes** ☐ **No**

Please note: if you answered Yes to (a), (b), or (c), this information will only be shared with EHS' Occupational Health as further assessment is required prior to respirator use.

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

PART 5: HEALTH CARE PROFESSIONAL PRIMARY ASSESSMENT (if required) – to be completed by Occupational Health Nurse

Assessment date: _____

Respirator use permitted: ☐ Yes ☐ No ☐ Uncertain

Referred to medical assessment: ☐ Yes ☐ No

Comments: _____

_____

Re-assessment date: _____

Name of Health Care Professional: _____ **Title:** _____

Signature of Health Care Professional: _____ **Date:** _____

PART 6: MEDICAL ASSESSMENT (if required) – to be completed by Occupational Health Physician

Assessment Date: _____

☐ Class 1. Respirator use is permitted with no restrictions

☐ Class 2. Respirator use is permitted with specific restrictions:
Specify: _____

☐ Class 3. Respirator use is NOT permitted.

Name of Physician: _____ **Title:** _____

Signature of Physician: _____ **Date:** _____