**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)**

1. 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

1. Have you had previous difficulty while using a respirator? **☐ Yes ☐ No**
2. 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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_