

**\*\* This form must be completed prior to your fit testing appointment.**

*This questionnaire will be used in determining whether or not you have a medical condition that may affect your ability to wear a respirator. All medical information is considered confidential.*

## SECTION 1: RESPIRATOR USE

### RESPIRATOR USER INFORMATION

Name: \_\_\_\_\_

McGill ID: \_\_\_\_\_

Department: \_\_\_\_\_

Email address: \_\_\_\_\_

**CONDITIONS OF RESPIRATOR USE** *Check more than one box, as required*

Check if used	TYPE OF RESPIRATOR	FREQUENCY approximate per month	EFFORT LEVEL physical exertion during use	DURATION approximate per use	TEMPERATURE during use
<input type="checkbox"/>	Filtering facepiece (N95 disposable)	_____ times per month	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	<input type="checkbox"/> < 15 min <input type="checkbox"/> Between 15 - 60 min <input type="checkbox"/> > 60 min	<input type="checkbox"/> < 0 °C <input type="checkbox"/> > 0 and < 25 °C <input type="checkbox"/> > 25 °C
<input type="checkbox"/>	Half-facepiece with filters and cartridges	_____ times per month	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	<input type="checkbox"/> < 15 min <input type="checkbox"/> Between 15 - 60 min <input type="checkbox"/> > 60 min	<input type="checkbox"/> < 0 °C <input type="checkbox"/> > 0 and < 25 °C <input type="checkbox"/> > 25 °C
<input type="checkbox"/>	Full facepiece with filters and cartridges	_____ times per month	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	<input type="checkbox"/> < 15 min <input type="checkbox"/> Between 15 - 60 min <input type="checkbox"/> > 60 min	<input type="checkbox"/> < 0 °C <input type="checkbox"/> > 0 and < 25 °C <input type="checkbox"/> > 25 °C
<input type="checkbox"/>	Supplied-air respirator (positive pressure helmet)	_____ times per month	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	<input type="checkbox"/> < 15 min <input type="checkbox"/> Between 15 - 60 min <input type="checkbox"/> > 60 min	<input type="checkbox"/> < 0 °C <input type="checkbox"/> > 0 and < 25 °C <input type="checkbox"/> > 25 °C
<input type="checkbox"/>	Self-contained breathing apparatus (SCBA)	_____ times per month	<input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	<input type="checkbox"/> < 15 min <input type="checkbox"/> Between 15 - 60 min <input type="checkbox"/> > 60 min	<input type="checkbox"/> < 0 °C <input type="checkbox"/> > 0 and < 25 °C <input type="checkbox"/> > 25 °C

## SECTION 2: RESPIRATOR USER'S HEALTH CONDITION

*Check only the box YES or NO. Please DO NOT write any additional medical information on this form.*

If wearing a full face respirator, will you need to wear glasses?  Yes  No

Have you ever had one of the following conditions that could interfere with the use of a respirator?  Yes  No

LIST OF CONDITIONS			
Shortness of breath	Respiratory difficulty	Chronic bronchitis	Asthma
Breathing difficulty when wearing a respirator	Pulmonary disease	Emphysema	Chest pain, on exertion
Heart conditions	Pacemaker	Cardiovascular disease	Thyroid problems
Diabetes	Hypertension/high pressure	Neuromuscular disease	Loss of consciousness
Vertigo/nausea	Claustrophobia/vertigo	Temperature sensitivity	Panic attacks
Hearing difficulty	Allergies	Color blindness	Decreased olfaction
Decreased taste	Dental prosthesis	Back/neck problems	Skin problems/special facial features
Eye disorder			

Have you ever had experienced difficulties wearing a respirator?  Yes  No

Do you have any concerns about your ability to use a respirator safely?  Yes  No

**\* NOTE: If you checked 'YES' for any of the questions above, a health care professional must complete an evaluation (SECTION 3) before the use of a respirator is approved.**

*To achieve full effectiveness of the respiratory protection device and to ensure optimal protection, nothing should interfere or impair the seal of the facepiece at the points of contact to the face or impede the proper functioning of the respirator. Possible interference with the seal are: facial hair, sideburns, hair,*

personal accessories, piercings, and personal protective equipment. You must be clean shaven when you wear a respirator. A 24-hour regrowth constitutes an acceptable limit.

I certify that I have understood all the above-mentioned questions and have answered to the best of my ability:

Employee's signature: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

EHS Representative: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### SECTION 3: EVALUATION BY A HEALTH CARE PROFESSIONAL

*Only necessary if 'YES' was indicated to any of the questions in Section 2 above*

Date of the consultation: \_\_\_\_\_

<b>ASSIGNMENT NOTICE (Check ✓)</b>			
TYPE OF RESPIRATOR USED	COMPLIES WITH THE MEDICAL REQUIREMENTS  and is  FIT TO WEAR A RESPIRATOR	FIT TO WEAR THE RESPIRATOR WITH LIMITATIONS (SPECIFY)	THE USE OF THIS RESPIRATOR IS  <u>FORBIDDEN</u>
1 Filtering facepiece (disposable)	<input type="checkbox"/>	<input type="checkbox"/> :	<input type="checkbox"/>
2 Half-facepiece with filters and cartridges	<input type="checkbox"/>	<input type="checkbox"/> :	<input type="checkbox"/>
3 Full facepiece with filters and cartridges	<input type="checkbox"/>	<input type="checkbox"/> :	<input type="checkbox"/>
4 Supplied-air respirator (with positive pressure helmet)	<input type="checkbox"/>	<input type="checkbox"/> :	<input type="checkbox"/>
5 Self-contained breathing apparatus (SCBA)	<input type="checkbox"/>	<input type="checkbox"/> :	<input type="checkbox"/>

Comments: \_\_\_\_\_

Name of the health care professional: \_\_\_\_\_ Title: \_\_\_\_\_

Signature of the health care professional \_\_\_\_\_

**Once completed, please return by email to [rpp.ehs@mcgill.ca](mailto:rpp.ehs@mcgill.ca)**