HARVARD
Campus Services
ENVIRONMENTAL HEALTH & SAFETY

Respiratory Protection Medical Evaluation Form for Employees

Instructions

Any Harvard employee required to wear a respirator as part of their work or research must:

1. Complete the Respiratory Protection Medical Evaluation Form or an equivalent form that meets 29 CFR 1910.134 requirements.
2. Have a physician or other licensed health care professional (PLHCP), such as a registered nurse, review the form.

Employees who voluntarily wear a reusable elastomeric respirator must also follow this procedure. Voluntary use of a disposable filtering facepiece respirator such as an N95 doesn't require a medical evaluation.

Respirator fit-testing can't be performed until the required medical evaluation is completed.

Form Section	Instructions
Section 1: Request for Medical Evaluation	Completed by the employee's supervisor or Respiratory Protection Coordinator.
Section 2: Health Care Provider's Recommendations	Leave blank for the Occupational Medicine Nurse to complete after they review Section 3. The Occupational Medicine Nurse reviews the form, completes Section 2, and sends a copy of only page 2 (Sections 1 and 2) to the employee.
Section 3: Medical Questionnaire	Completed by the employee who will wear the respirator. The employee submits the information independently and confidentially to the Harvard Occupational Medicine Nurse. If the employee needs help understanding the questions, they should contact the Occupational Medicine Nurse directly.

Email the completed form with encryption to tracie_ercolini@harvard.edu

Tracie Ercolini, RN Harvard Occupational Medicine Nurse

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Respiratory Protection Medical Evaluation Form

Section 1: Request for Medical Evaluation

Employee name: Harvard ID number:

Job title: School/Department:

Phone number:

Harvard email address:

Requesting Supervisor name: Phone number:

Harvard email address:

Signature: Date:

Section 2: Health Care Provider's Recommendation

A physician or other licensed healthcare professional must complete this section. This recommendation is made using the medical questionnaire in Section 3 or an initial medical exam that obtains the same information as the questionnaire.

☐ Not medically cleared for respirator use ☐ Follow-up medical evaluation required

Medically cleared for respirator use with: ☐ No restrictions or ☐ With the following restrictions:

Comments:

By my signature, I also indicate that a copy of this recommendation was provided to the employee.

Health care provider name:

Health care provider signature: Date:

Section 3: Medical Questionnaire

To the employee:

Are you able to read and understand the questions contained in this evaluation? ☐ Yes ☐ No

The University must allow you to answer this questionnaire during normal working hours or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers and your employer has told you (on page 1) how to deliver or send this questionnaire confidentially to the health care professional who will review it.

Part A. Section 1

This information must be provided by every employee selected to use any type of respirator (please print).

Today's date: Sex: ☐ Male ☐ Female

Name: Date of birth:

Height: feet inches Weight: pounds

Phone number:

Best time to call you at this phone number:

Job title: (☐ Not applicable if student)

Has your employer told you how to contact the health care professional who will review this questionnaire?

☐ Yes ☐ No

Check the type of respirator you'll use (you may check more than one):

☐ Filtering facepiece (N95, such as for hospitals or clinics) ☐ Powered air purifying respirator (PAPR)

☐ Half-face air-purifying respirator (APR) ☐ Self-contained breathing apparatus (SCBA)

☐ Full-face APR ☐ Air line

Have you ever worn a respirator? ☐ Yes ☐ No If yes, what types?

Part A. Section 2.1

This section is required for all respirator users: Every employee selected to use any type of respirator must answer questions 1 through 9.

1.	Do you currently smoke tobacco, or did you smoke tobacco in the last month?	☐ Yes	☐ No
2.	Have you ever had any of the following conditions?		
	Seizures (fits)	☐ Yes	☐ No
	Diabetes (sugar disease)	☐ Yes	☐ No
	Allergic reactions that interfere with your breathing	☐ Yes	☐ No
	Claustrophobia (fear of closed-in places)	☐ Yes	☐ No
	Trouble smelling odors	☐ Yes	☐ No
3.	Have you ever had any of the following pulmonary or lung problems?		
	Asbestosis	☐ Yes	☐ No
	Asthma	☐ Yes	☐ No
	Chronic bronchitis	☐ Yes	☐ No
	Emphysema	☐ Yes	☐ No
	Pneumonia	☐ Yes	☐ No
	Tuberculosis	☐ Yes	☐ No
	Silicosis	☐ Yes	☐ No
	Pneumothorax (collapsed lung)	☐ Yes	☐ No
	Lung cancer	☐ Yes	☐ No
	Broken ribs	☐ Yes	☐ No
	Any chest injuries or surgeries	☐ Yes	☐ No
	Any other lung problem that you were told about	☐ Yes	☐ No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath	☐ Yes	☐ No
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐ Yes	☐ No
Shortness of breath when walking with other people at an ordinary pace on level ground	☐ Yes	☐ No
Have to stop for breath when walking at your own pace on level ground	☐ Yes	☐ No
Shortness of breath when washing or dressing yourself	☐ Yes	☐ No
Shortness of breath that interferes with your job	☐ Yes	☐ No
Coughing that produces phlegm (thick sputum)	☐ Yes	☐ No
Coughing that wakes you early in the morning	☐ Yes	☐ No
Coughing that occurs mostly when you're lying down	☐ Yes	☐ No
Coughing up blood in the last month	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Wheezing that interferes with your job	☐ Yes	☐ No
Chest pain when you breathe deeply	☐ Yes	☐ No
Any other symptoms that you think may be related to lung problems	☐ Yes	☐ No

5. Have you ever had any of the following cardiovascular or heart problems?

Heart attack	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Heart failure	☐ Yes	☐ No
Swelling in your legs or feet (not caused by walking)	☐ Yes	☐ No

Heart arrhythmia (heart beating irregularly)	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Any other heart problem that you have been told about	☐ Yes	☐ No

6. Have you ever had any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest	☐ Yes	☐ No
Pain or tightness in your chest during physical activity	☐ Yes	☐ No
Pain or tightness in your chest that interferes with your job	☐ Yes	☐ No
In the past two years, have you noticed your heart skipping or missing a beat	☐ Yes	☐ No
Heartburn or indigestion that is not related to eating	☐ Yes	☐ No
Any other symptoms that you think may be related to heart or circulation problems	☐ Yes	☐ No

7. Do you currently take medication for any of the following problems?

Breathing or lung problems	☐ Yes	☐ No
Heart trouble	☐ Yes	☐ No
Blood pressure	☐ Yes	☐ No
Seizures (fits)	☐ Yes	☐ No

8. If you've used a respirator, have you ever had any of the following problems?

☐ If you've never used a respirator, check here and move on to question 9.

Eye irritation	☐ Yes	☐ No
Skin allergies or rashes	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No

General weakness or fatigue	☐ Yes	☐ No
Any other problem that interferes with your use of a respirator	☐ Yes	☐ No

9. Would you like to discuss your answers with the health care professional who will review this questionnaire? ☐ Yes ☐ No

Part A. Section 2.2

This section is required for full-facepiece respirator or SCBA users and optional for other respirator users: Every employee selected to use either a full-facepiece respirator or a SCBA must answer questions 10 through 15. For employees selected to use all other types of respirators, such as N95s or half-facepiece respirators, these questions are optional.

10. Have you ever lost vision in either eye (temporarily or permanently)? ☐ Yes ☐ No

11. Do you currently have any of the following vision problems?

Wear contact lenses	☐ Yes	☐ No
Wear glasses	☐ Yes	☐ No
Color blind	☐ Yes	☐ No
Any other eye or vision problem	☐ Yes	☐ No

12. Have you ever had an injury to your ears, including a broken ear drum? ☐ Yes ☐ No

13. Do you currently have any of the following hearing problems?

Difficulty hearing	☐ Yes	☐ No
Wear a hearing aid	☐ Yes	☐ No
Any other hearing or ear problem	☐ Yes	☐ No

14. Have you ever had a back injury? ☐ Yes ☐ No

15. Do you currently have any of the following musculoskeletal problems?

Weakness in any of your arms, hands, legs, or feet	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Difficulty fully moving your arms and legs	☐ Yes	☐ No
Pain or stiffness when you lean forward or backward at the waist	☐ Yes	☐ No
Difficulty fully moving your head up or down	☐ Yes	☐ No
Difficulty fully moving your head side to side	☐ Yes	☐ No
Difficulty bending at your knees	☐ Yes	☐ No
Difficulty squatting to the ground	☐ Yes	☐ No
Climbing a flight of stairs or a ladder carrying more than 25 lbs.	☐ Yes	☐ No
Any other muscle or skeletal problems that interferes with using a respirator	☐ Yes	☐ No

Part B. Additional Information

DO NOT COMPLETE this part unless the Occupational Medicine Nurse follows up with these questions.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? ☐ Yes ☐ No

If yes, do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions? ☐ Yes ☐ No

2. At work or at home, were you ever exposed to or come into skin contact with hazardous solvents or hazardous airborne chemicals (like gases, fumes, or dust)? ☐ Yes ☐ No

If yes, name the chemicals if you know them:

3. Have you ever worked with any of these materials or under any of these conditions?

Asbestos	☐ Yes	☐ No
Silica (for example, in sandblasting)	☐ Yes	☐ No
Tungsten or cobalt (for example, grinding or welding this material)	☐ Yes	☐ No

Beryllium	☐ Yes	☐ No
Aluminum	☐ Yes	☐ No
Coal (for example, mining)	☐ Yes	☐ No
Iron	☐ Yes	☐ No
Tin	☐ Yes	☐ No
Dusty environments	☐ Yes	☐ No
Any other hazardous exposures	☐ Yes	☐ No

If yes, describe these exposures:

4. List any second jobs or side businesses you have:

5. List your previous occupations:

6. List your current and previous hobbies:

7. Have you been in the military services? ☐ Yes ☐ No

If yes, were you exposed to biological or chemical agents (either in training or combat)? ☐ Yes ☐ No

8. Have you ever worked on a HAZMAT team? ☐ Yes ☐ No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)? ☐ Yes ☐ No

If yes, name the medications if you know them:

10. Will you be using any of the following items with your respirator(s)?

HEPA filters ☐ Yes ☐ No

Canisters (for example, gas masks) ☐ Yes ☐ No

Cartridges ☐ Yes ☐ No

11. How often are you expected to use the respirator(s)? (check all that apply)

☐ Escape only (no rescue) ☐ Fewer than 5 hours per week ☐ 2 to 4 hours per day

☐ Emergency rescue only ☐ Fewer than 2 hours per day ☐ Over 4 hours per day

12. During the period you're using the respirator(s), describe your work effort:

Light (less than 200 kcal per hour) ☐ Yes ☐ No

Examples: sitting while writing, typing, drafting, or performing light assembly work; standing while operating a drill press (1-3 lbs.) or controlling machines.

If yes, how long does this period last during the average shift: ____ hours ____minutes

Moderate (200 to 350 kcal per hour) ☐ Yes ☐ No

Examples: sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

If yes, how long does this period last during the average shift: ____ hours ____minutes

Heavy (above 350 kcal per hour) ☐ Yes ☐ No

Examples: lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

If yes, how long does this period last during the average shift: ____ hours ____minutes

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? ☐ Yes ☐ No

If yes, describe this protective clothing and/or equipment:

14. Will you be working under hot conditions (temperature exceeding 77° Fahrenheit)? ☐ Yes ☐ No

15. Will you be working under humid conditions? ☐ Yes ☐ No

16. Describe the work you'll be doing while using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces or life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

- Name(s) of toxic substance(s)
- Estimated maximum exposure level per shift
- Duration of exposure per shift

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue or security):

To request this document in an alternative format contact ehs@harvard.edu