NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE HEALTH SERVICE
Medical Assessment for Respirator Use

EHS-701.8 (3/2020 L)

AGENCY REQUESTING MEDICAL ASSESSMENT

Agency Name and Address	Contact Name	Agency Code
	Voice Telephone:	
	Fax Number:	

Personal Privacy Protection Law Notification

The information you provide on this form is being requested for the principal purpose of conducting a medical assessment for respirator use. The information will be used in accordance with section 96(1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to conduct such medical assessment. This information will be maintained by the Director, Employee Health Service, Department of Civil Service, 55 Mohawk Street, Cohoes, NY 12047; telephone (518) 233.3100. For information concerning the Personal Privacy Protection Law, call (518) 457-9375.

Employee Affirmation/Signature

I affirm that the information provided is accurate and complete to the best of my knowledge. I understand that all statements made by me in connection with this assessment are subject to review and verification and that any material misstatements or fraud may result in a referral for disciplinary action.

_____ _____

Employee Signature Date

The following information MUST be provided by every employee whose job duties require the use of any type of respirator. Your employer MUST allow you to answer this questionnaire during normal working hours or at a time and place convenient to you. To maintain your confidentiality your employer or supervisor must not look at or review your answers and your employer or supervisor must tell you how to deliver or send this questionnaire to the health care professional who will review it.

PLEASE PRINT					
Today's Date:	Name:				Social Security Number
Weight	Height	Sex	Date of Birth	Age	Job Title
	Feet: _____ Inches: _____	☐ Male ☐ Female			
Work Phone ( )	Best Time(s) to Reach You at This Number				
Work Location			Home Address		

1. Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ YES ☐ NO

2. Check the type of respirator you will use (you can check more than one category)

   ☐ Disposable Filter Respirator (dust mask type only)
   ☐ Cartridge/Canister Respirator
   ☐ Positive Air-Purifying Respirator (PAPR)
   ☐ Supplied Air Respirator
   ☐ Self-Contained Breathing Apparatus (SCBA)

3. Have you worn a respirator? ☐ YES ☐ NO

   If YES, what type(s): _____

PART A SECTION 2 Mandatory Employee Information	
Questions 1 through 9 below MUST be answered by every employee who will be using any type of respirator. Please Check YES or NO. **EXPLAIN ANY CONDITIONS CHECKED "YES" IN THE SPACE PROVIDED.**	
1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month?	☐ YES ☐ NO
2. Have you **ever** had any of the following conditions?	
a. Seizures	☐ YES ☐ NO
b. Diabetes	☐ YES ☐ NO
c. Allergic reactions that interfere with your breathing	☐ YES ☐ NO
d. Claustrophobia (fear of closed-in places)	☐ YES ☐ NO
e. Trouble smelling odors	☐ YES ☐ NO
If YES, please explain any conditions which you checked above:	
3. Have you *ever* had any of the following pulmonary or lung problems?	
a. Asbestosis	☐ YES ☐ NO
b. Asthma	☐ YES ☐ NO
c. Chronic bronchitis	☐ YES ☐ NO
d. Emphysema	☐ YES ☐ NO
e. Pneumonia	☐ YES ☐ NO
f. Tuberculosis	☐ YES ☐ NO
g. Silicosis	☐ YES ☐ NO
h. Pneumothorax (collapsed lung)	☐ YES ☐ NO
i. Lung Cancer	☐ YES ☐ NO

	j. Broken ribs	☐ YES ☐ NO
	k. Any chest injuries or surgeries	☐ YES ☐ NO
	l. Any other lung problem that you've been told about	☐ YES ☐ NO
	If YES, please explain any conditions which you checked above:	

4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
	a. Shortness of breath	☐ YES ☐ NO
	b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐ YES ☐ NO
	c. Shortness of breath when walking with other people at an ordinary pace on level ground	☐ YES ☐ NO
	d. Have to stop for breath when walking at your own pace on level ground	☐ YES ☐ NO
	e. Shortness of breath when washing or dressing yourself	☐ YES ☐ NO
	f. Shortness of breath that interferes with your job	☐ YES ☐ NO
	g. Coughing that produces phlegm (thick sputum)	☐ YES ☐ NO
	h. Coughing that wakes you early in the morning	☐ YES ☐ NO
	i. Coughing that occurs mostly when you are lying down	☐ YES ☐ NO
	j. Coughing up blood in the last month	☐ YES ☐ NO
	k. Wheezing	☐ YES ☐ NO
	l. Wheezing that interferes with your job	☐ YES ☐ NO
	m. Chest pain when you breathe deeply	☐ YES ☐ NO
	n. Any other symptoms that you think may be related to lung problems	☐ YES ☐ NO
	If YES, please explain any conditions which you checked above:	

5. Have you ***ever*** had any of the following cardiovascular or heart problems?		
	a. Heart Attack	☐ YES ☐ NO
	b. Stroke	☐ YES ☐ NO
	c. Angina	☐ YES ☐ NO
	d. Heart failure	☐ YES ☐ NO
	e. Swelling in your legs or feet (not caused by walking)	☐ YES ☐ NO
	f. Heart arrhythmia (heart beating irregularly)	☐ YES ☐ NO
	g. High blood pressure	☐ YES ☐ NO
	h. Any other heart problem that you've been told about	☐ YES ☐ NO
	If YES, please explain any conditions which you checked above:	

6. Have you ***ever*** had any of the following cardiovascular or heart symptoms?		
	a. Frequent pain or tightness in your chest	☐ YES ☐ NO
	b. Pain or tightness in your chest during physical activity	☐ YES ☐ NO
	c. Pain or tightness in your chest that interferes with your job	☐ YES ☐ NO
	d. In the past two years, have you noticed your heart skipping or missing a beat	☐ YES ☐ NO
	e. Heartburn or indigestion that is not related to eating	☐ YES ☐ NO
	f. Any other symptoms that you think may be related to heart or circulation problems	☐ YES ☐ NO
	If YES, please explain any conditions which you checked above:	
7. Do you currently take medication for any of the following problems?		
	a. Breathing or lung problems	☐ YES ☐ NO
	b. Heart trouble	☐ YES ☐ NO
	c. Blood pressure	☐ YES ☐ NO
	d. Seizures	☐ YES ☐ NO
	If YES, please explain any conditions which you checked above:	
8. Have you ***ever*** used a respirator before?		☐ YES ☐ NO
	If YES, have you ever had any of the following problems? If NO, proceed to question 9.	
	a. Eye irritation	☐ YES ☐ NO
	b. Skin allergies or rashes	☐ YES ☐ NO
	c. Anxiety	☐ YES ☐ NO
	d. General weakness or fatigue	☐ YES ☐ NO
	e. Any other problem that interferes with your use of a respirator	☐ YES ☐ NO
	If YES, please explain any conditions which you checked above:	
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?		☐ YES ☐ NO

PART A SECTION 3 Special Employee Information

Questions 10 through 15 below must be answered by everyone whose job duties require the use of either a FULL-FACEPIECE respirator or a SELF-CONTAINED BREATHING APPARATUS (SCBA).

For employees whose job duties require the use of other types of respirators, answering these questions is voluntary.

10. Have you ***ever*** lost vision in either eye (temporarily or permanently)?		☐ YES ☐ NO
	If YES, please explain:	
11. Do you ***currently*** have any of the following vision problems?		
	a. Wear contact lenses	☐ YES ☐ NO
	b. Wear glasses	☐ YES ☐ NO
	c. Color blind	☐ YES ☐ NO
	d. Any other eye or vision problem	☐ YES ☐ NO
	If YES, please explain any conditions which you checked above:	
12. Have you ***ever*** had an injury to your ears, including a broken ear drum?		☐ YES ☐ NO
	If YES, please explain:	
13. Do you ***currently*** have any of the following hearing problems?		
	a. Difficulty hearing	☐ YES ☐ NO
	b. Wear a hearing aid	☐ YES ☐ NO
	c. Any other hearing or ear problem	☐ YES ☐ NO
	If YES, please explain any conditions which you checked above:	

14. Have you ***ever*** had a back injury?		☐ YES ☐ NO
	If YES, please explain:	
15. Do you ***currently*** have any of the following musculoskeletal problems?		
	a. Weakness in any of your arms, hands, legs or feet	☐ YES ☐ NO
	b. Back pain	☐ YES ☐ NO
	c. Difficulty fully moving your arms and legs	☐ YES ☐ NO
	d. Pain or stiffness when you lean forward or backward at the waist	☐ YES ☐ NO
	e. Difficulty fully moving your head up or down	☐ YES ☐ NO
	f. Difficulty fully moving your head side to side	☐ YES ☐ NO
	g. Difficulty bending at your knees	☐ YES ☐ NO
	h. Difficulty squatting to the ground	☐ YES ☐ NO
	i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.	☐ YES ☐ NO
	j. Any other muscle or skeletal problem that interferes with using a respirator	☐ YES ☐ NO
	If YES, please explain any conditions which you checked above:	

PART B

Questions 1 through 19 below must be answered by every employee whose job duties require the use of a CARTRIDGE/CANISTER RESPIRATOR, PAPR, SUPPLIED AIR RESPIRATOR AND/OR SCBA.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has a lower than normal amount of oxygen?	☐ YES ☐ NO
If YES, do you have:	
a. feelings of dizziness	☐ YES ☐ NO
b. shortness of breath	☐ YES ☐ NO
c. pounding in your chest	☐ YES ☐ NO
d. Other symptoms when you're working under these conditions	☐ YES ☐ NO
If YES, please explain any conditions which you checked above:	

2. At work or at home, have you ***ever*** been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gasses, fumes, or dust), or have you come into skin contact with hazardous chemicals?	☐ YES ☐ NO
If YES, name the chemicals, if you know them:	
3. Have you ***ever*** worked with any of the materials, or under any of the conditions listed below?	
a. Asbestos	☐ YES ☐ NO
b. Silica (e.g., in sandblasting)	☐ YES ☐ NO
c. Tungsten/cobalt (e.g., grinding or welding this material)	☐ YES ☐ NO
d. Beryllium	☐ YES ☐ NO
e. Aluminum	☐ YES ☐ NO
f. Coal (for example, mining)	☐ YES ☐ NO
g. Iron	☐ YES ☐ NO
h. Tin	☐ YES ☐ NO
i. Dusty environments	☐ YES ☐ NO
j. Any other hazardous exposures?	☐ YES ☐ NO
If YES, describe these exposures:	
4. List any second jobs or side businesses you have:	
5. List your current and previous hobbies:	
6. List your previous occupations:	

7. Have you been in the military services?	☐ YES ☐ NO
If YES, were you exposed to biological or chemical agents (in either training or	☐ 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)?:	
a. HEPA filters	☐ YES ☐ NO
b. Canisters (e.g., gas masks)	☐ YES ☐ NO
c. Cartridges	☐ YES ☐ NO
11. How often are you expected to use the respirator(s) – check YES or NO for all answers that **apply** to you:?	
a. Escape only (no rescue)	☐ YES ☐ NO
b. Emergency rescue only	☐ YES ☐ NO
c. Less than 5 hours per week	☐ YES ☐ NO
d. Less than 2 hours per day	☐ YES ☐ NO
e. 2 to 4 hours per day	☐ YES ☐ NO
f. Over 4 hours per day	☐ YES ☐ NO
12. During the period you are using the respirator(s), is your work effort?	
a. Light (less than 200 kcal per hour)	☐ YES ☐ NO
If YES, how long does this period last during the average shift?_____Hours _____ Minutes (Examples of light work effort are sitting while typing, drafting, or performing light assembly work, or standing while operating a drill press (1-3 lbs.) or controlling machines)	
b. Moderate (200 to 350 kcal per hour)	☐ YES ☐ NO
If YES, how long does this period last during the average shift? ____ Hours ____ Minutes (Examples of moderate work effort are 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; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface)	
c. Heavy (above 350 kcal per hour)	☐ YES ☐ NO
If YES, how long does this period last during the average shift? ____ Hours _____ Minutes (Examples of heavy work are 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.)	
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 the protective clothing and/or equipment	

14. Will you be working under hot conditions (temperature exceeding 77 degrees F)?	☐ YES ☐ NO
15. Will you be working under humid conditions?	☐ YES ☐ NO

16. Describe the work you will be doing while using your respirator:

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

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 of the first toxic substance _____

Estimated maximum exposure level per shift _____

Duration of exposure per shift _____

Name of the second toxic substance _____

Estimated maximum exposure level per shift _____

Duration of exposure per shift _____

Name of the third toxic substance _____

Estimated maximum exposure level per shift _____

Duration of exposure per shift _____

The name of any other toxic substances that you'll be exposed to while using your respirator

_____

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

HEALTH CARE PROVIDER USE ONLY

Notes/Follow-up Inquiries for Positive Responses:

_____ _____ _____

Provider Name **Provider Signature** **Date**