

OSHA INFOSHEET

Respirator Medical Evaluation Questionnaire

Respirators must be used in workplaces in which employees are exposed to hazardous airborne contaminants. When respiratory protection is required employers must have a respirator protection program as specified in OSHA's Respiratory Protection standard (29 CFR 1910.134). Before wearing a respirator, workers must first be medically evaluated using the mandatory medical questionnaire or an equivalent method. To facilitate these medical evaluations, this INFOSHEET includes the mandatory medical questionnaire to be used for these evaluations.

Medical Evaluation and Questionnaire Requirements

The requirements of the medical evaluation and for using the questionnaire are provided below:

- The employer must identify a physician or other licensed health care professional (PLHCP) to perform all medical evaluations using the medical questionnaire in Appendix C of the Respiratory Protection standard or a medical examination that obtains the same information. (See Paragraph (e)(2)(i).)
- The medical evaluation must obtain the information requested in Sections 1 and 2, Part A of Appendix C. The questions in Part B of Appendix C may be added at the discretion of the health care professional. (See Paragraph (e)(2)(ii).)
- The employer must ensure that a follow-up medical examination is provided for any employee who gives a positive response to any question among questions 1 through 8 in Part A Section 2, of Appendix C, or whose initial medical examination demonstrates the need for a follow-up medical examination. The employer must provide the employee with an opportunity to discuss the questionnaire and examination results with the PLHCP. (See Paragraph (e)(3)(i).)
- The medical questionnaire and examinations must be administered confidentially during the employee's normal working hours or at a time and place convenient to the employee and in a manner that ensures that he or she understands its content. The employer must not review the employee's responses, and the questionnaire must be provided directly to the PLHCP. (See Paragraph (e)(4)(i).)

Excerpt from Appendix C of 29 CFR 1910.134: OSHA Respirator Medical Evaluation Questionnaire

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee: Your employer 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 must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Once filled out, this form must be given to the PLHCP. This form should **not** be submitted to OSHA.

Part A Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:
2. Your name:
3. Your age (to nearest year):
4. Sex (circle one): Male/Female
5. Your height: ft. in.
6. Your weight: lbs.
7. Your job title:
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):
9. The best time to phone you at this number:
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No
11. Check the type of respirator you will use (you can check more than one category):
 - a. N, R, or P disposable respirator (filter-mask, non-cartridge type only).
 - b. Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (circle one): Yes/No If "yes," what type(s):

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

	YES	NO
1. Do you <i>currently</i> smoke tobacco, or have you smoked tobacco in the last month?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you <i>ever had</i> any of the following conditions?		
a. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
b. Diabetes (sugar disease)	<input type="checkbox"/>	<input type="checkbox"/>
c. Allergic reactions that interfere with your breathing	<input type="checkbox"/>	<input type="checkbox"/>
d. Claustrophobia (fear of closed-in places)	<input type="checkbox"/>	<input type="checkbox"/>
e. Trouble smelling odors	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you <i>ever had</i> any of the following pulmonary or lung problems?		
a. Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
c. Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
d. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
e. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
f. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
g. Silicosis	<input type="checkbox"/>	<input type="checkbox"/>
h. Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>
i. Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>
j. Broken ribs	<input type="checkbox"/>	<input type="checkbox"/>
k. Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/>
l. Any other lung problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you <i>currently</i> have any of the following symptoms of pulmonary or lung illness?	<input type="checkbox"/>	<input type="checkbox"/>
a. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/>	<input type="checkbox"/>
c. Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
d. Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
e. Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>
f. Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
g. Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>
h. Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>
i. Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/>
j. Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/>
k. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
l. Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
m. Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/>
n. Any other symptoms that you think may be related to lung problems	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you <i>ever had</i> any of the following cardiovascular or heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
a. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
b. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
c. Angina	<input type="checkbox"/>	<input type="checkbox"/>
d. Heart failure	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
e. Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/>	<input type="checkbox"/>
f. Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/>	<input type="checkbox"/>
g. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
h. Any other heart problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had any of the following cardiovascular or heart symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
a. Frequent pain or tightness in your chest	<input type="checkbox"/>	<input type="checkbox"/>
b. Pain or tightness in your chest during physical activity	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain or tightness in your chest that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past two years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/>	<input type="checkbox"/>
e. Heartburn or indigestion that is not related to eating	<input type="checkbox"/>	<input type="checkbox"/>
f. Any other symptoms that you think may be related to heart or circulation problems	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you currently take medication for any of the following problems?	<input type="checkbox"/>	<input type="checkbox"/>
a. Breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
b. Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
c. Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
d. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9.)	<input type="checkbox"/>	<input type="checkbox"/>
a. Eye irritation	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin allergies or rashes	<input type="checkbox"/>	<input type="checkbox"/>
c. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
d. General weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>
e. Any other problem that interferes with your use of a respirator	<input type="checkbox"/>	<input type="checkbox"/>
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	<input type="checkbox"/>	<input type="checkbox"/>
<p>Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.</p>		
10. Have you ever lost vision in either eye (temporarily or permanently)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you currently have any of the following vision problems?	<input type="checkbox"/>	<input type="checkbox"/>
a. Wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
b. Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>
c. Color blind	<input type="checkbox"/>	<input type="checkbox"/>
d. Any other eye or vision problem	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
12. Have you ever <i>had</i> an injury to your ears, including a broken eardrum?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you <i>currently</i> have any of the following hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>
a. Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>
b. Wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>
c. Any other hearing or ear problem	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever <i>had</i> a back injury?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you <i>currently</i> have any of the following musculoskeletal problems?	<input type="checkbox"/>	<input type="checkbox"/>
a. Weakness in any of your arms, hands, legs, or feet	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain	<input type="checkbox"/>	<input type="checkbox"/>
c. Difficulty fully moving your arms and legs	<input type="checkbox"/>	<input type="checkbox"/>
d. Pain and stiffness when you lean forward or backward at the waist	<input type="checkbox"/>	<input type="checkbox"/>
e. Difficulty fully moving your head up or down	<input type="checkbox"/>	<input type="checkbox"/>
f. Difficulty fully moving your head side to side	<input type="checkbox"/>	<input type="checkbox"/>
g. Difficulty bending at your knees	<input type="checkbox"/>	<input type="checkbox"/>
h. Difficulty squatting to the ground	<input type="checkbox"/>	<input type="checkbox"/>
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>
j. Any other muscle or skeletal problem that interferes with using a respirator	<input type="checkbox"/>	<input type="checkbox"/>

This infosheet does not include the questions in Part B because they are not mandatory; rather, they may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

OSHA Educational Materials

OSHA has an extensive publications program. For a listing of free items, visit OSHA's web site at www.osha.gov/publications or contact the OSHA Publications Office, U.S. Department of

Labor, 200 Constitution Avenue, N.W., N-3101, Washington, DC 20210. Telephone (202) 693-1888 or fax to (202) 693-2498.

Contacting OSHA

To report an emergency, file a complaint or seek OSHA advice, assistance or products, call (800) 321-OSHA (6742) or contact your nearest OSHA regional, area, or State Plan office; TTY: 1-877-889-5627.

This InfoSheet is not a standard or regulation, and it creates no new legal obligations. It contains recommendations as well as descriptions of mandatory safety and health standards. The recommendations are advisory in nature, informational in content, and are intended to assist employers in providing a safe and healthful workplace. The *Occupational Safety and Health Act* requires employers to comply with safety and health standards and regulations promulgated by OSHA or by a state with an OSHA-approved state plan. In addition, the Act's General Duty Clause, Section 5(a)(1), requires employers to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm.



U.S. Department of Labor



Fit testing procedure for N95 Respirators (Using 3M FT-30, Bitter Fit Test Equipment)

DATE COMPLETED	Step-By-Step Process
	<p>1. Obtain Medical evaluation (OSHA medical evaluation questionnaire is attached)</p> <ul style="list-style-type: none"> • Subjects should be informed of the ingredients of the fit test solution and that they will be exposed to a fine mist. Ingredients: Water, sodium chloride, denatonium benzoate. <p style="text-align: center;">(Once Completed Continue to Step 2)</p>
	<p>2. Preparation of equipment</p> <ul style="list-style-type: none"> • Put hood onto collar. • Pour a small amount (approximately one teaspoonful) of the Sensitivity Test Solution into the nebulizer labeled "#1 Sensitivity Test Solution." • Pour the same amount of Fit Test Solution into the second nebulizer labeled "#2 Fit Test Solution." • Immediately recap the bottles. <p style="text-align: center;">(Once Completed Continue to Step 3)</p>
	<p>3. Sensitivity Test (This test is done to assure that the person being fit tested can detect the bitter taste of the test solution at very low levels.) The test subject should not eat, drink (except water), or chew gum for 15 minutes before the test.</p> <ul style="list-style-type: none"> • Have the test subject put on the hood and collar assembly without a respirator. • Position the hood assembly forward so that there is about six inches between the subject's face and the hood window. • Instruct the test subject to breathe through his/her mouth with tongue extended. • Using Nebulizer #1 with the Sensitivity Test Solution, inject the aerosol into the hood through the hole in the hood window. Inject ten squeezes of the bulb, fully collapsing and allowing the bulb to expand fully on each squeeze. Both plugs on the nebulizer must be removed from the openings during use. The nebulizer must be held in an upright position to ensure aerosol generation. • Ask the test subject if he/she can detect the bitter taste of the solution. If tasted, note the number of squeezes as 10 and proceed to the Fit Test. • If not tasted, inject an additional ten squeezes of the aerosol into the hood. Repeat with ten more squeezes if necessary. Note whether 20 or 30 squeezes produced a taste response. • If 30 squeezes do not cause the subject to detect a bitter taste, the test is ended. • Remove the test hood. Rinse his/her mouth with water. <p style="text-align: center;">(Once Completed Continue to Step 4)</p>

	<p>4. Fit Test</p> <ul style="list-style-type: none"> • Have the test subject don the respirator and perform a user seal check per the instructions provided on the respirator package. • Have the subject put on test hood. • Using Nebulizer #2 with Fit Test Solution, inject the fit test aerosol using the same number of squeezes as required in the Sensitivity Test (10, 20 or 30). A minimum of ten squeezes is required, fully collapsing and allowing the bulb to expand fully on each squeeze. The nebulizer must be held in an upright position to ensure aerosol generation. • Inject one-half the number of squeezes (5, 10, or 15) every 30 seconds for the duration of the fit test procedure. • After the initial injection of aerosol, ask the test subject to perform the following test exercises for 60 seconds each: <ul style="list-style-type: none"> ◦ Normal breathing – In a normal standing position, without ---- talking, the subject shall breath normally. ◦ Deep breathing – In a normal standing position, the subject shall breathe slowly and deeply, taking caution so as not to hyperventilate. ◦ Turning head side to side – ◦ Moving head up and down – ◦ Talking – The subject shall talk out loud. ◦ Bending over – The test subject shall bend at the waist as if he/she were to touch his/her toes. Jogging in place may be substituted for the exercise. ◦ Normal breathing – <p><i>The test is terminated at any time the bitter taste of aerosol is detected by the subject because this indicates an inadequate fit. Wait 15 minutes and perform the sensitivity test again.</i></p> <p>If the entire test is completed without the subject detecting the bitter taste of the aerosol, the test is successful and respirator fit has been demonstrated. (Once Completed Continue to Step 5)</p>
	<p>5. Cleaning</p> <ul style="list-style-type: none"> • At the end of each session or at least every four hours, discard the unused solutions from the nebulizers. Do not pour unused solutions back into bottles. • Rinse the nebulizers with warm. • Wipe out the inside of the hood with a damp cloth or paper towel.