]			\boxtimes	

3. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one) Yes B BNB B B – ED Occupational

(Mandatory) Questions 1 through 9 below must be answered by every

o").

	a.	Seizures (fits)	
	b.	Diabetes (sugar disease)	
	C.	Allergic reactions that interfere with your breathing	
	d.	Claustrophobia (fear of closeid places)	
	e.	Trouble smelling odors	
3.	Ha	ve you ever hadany of the following pulmonary or lung problems?	
	a.	Asbestosis	
	b.	Asthma	
	c.	Chronic bronchitis	
	d.	Emphysema	
	e.	Pneumonia	
	f.	Tuberculosis	
	g.	Silicosis	
	h.	Pneumothorax (collapsed lung)	
	i.	Lung Cancer	
	j.	Broken ribs	



Part A Section 2 (Continue)

k. Any chest injuries or surgeries

Yes

No



Part A Section 2 (Continue)	Yes	No
b. Heart trouble		
c. Blood pressure		
d. Seizures (fits)		
a. Eye Irritation		
b. Skin allergies or rashes		
c. Anxiety		
d. General weakness or fatigue		
e. Any other problem that interferes with your use respirator		

7 KH EHORZ VUIFWWALHROGHLWLHHRZLQJ 1 XUVH DQG WKH 3K\VLFLDQ RU RWK 3/+&3

INSTRUCTIONS: A Registered Nurse will review Questions 49 in Part A, Section 2.If an employee marks NO to all 9 questions, the Reviewing Nursewill mark the box indicating "No restrictions on respirator use" If an employee marks yes to any of the first 9 questions, the eviewing Nursewill forward to a PLHCP review by marking the box indicating "Follow-up medical evaluation needed."

CLEARANCE (CHECK ONE)						
No restrictions on respirator use	‰	Follow-up medicalevaluation needed ‰				
Reviewing Nurse:		(Signature				
The reviewing PLHCP will determine the employee's ability to wear a respirator. The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.						
FOLLOW UP MEDICAL EVALUATION (CHECK ONE)						
Respirator use not Permitted	‰	Respirator use with restrictions %				
No restrictions on respirator use	‰					

Noted Restrictions:

ExaminingPLHCP:

(Signature)



Respiratory Fit Test Record

Name	Date of Birth	Rocket ID#
Department	Job Title	Daytime Phone #