

Applicant Information - Please print legibly if applicable.

Today's Date:	Date of Birth:	Height:	(ft)	(in)
Name: (Last, First):	UFID:	Weight:		(lbs)
Department:	Phone:	Sex:	M	F

Has the Payment Authorization Form been submitted?	Yes	No	Can you read English?	Do you exercise? If "yes," describe activity and frequency:	Yes	No
Has your employer told you how to contact the health care professional who will review this?	Yes	No			Yes	No

Select the type of respirator you will use (you can check more than one category):

Disposable, filter mask, non-cartridge type only:
Filtering Facepiece, N95, N99, NI100, R or P

Other: Half - or full-facepiece, powered air-purifying, supplied-air, self-contained breathing apparatus (SCBA)

Have you worn a respirator in the past?

No Please select "Initial Medical Evaluation" at right & then skip to [Medical Questionnaire Section](#)

Yes If yes, what type(s):

Select Exam Type:

Use:

Respiratory Protection Only
Respiratory Protection and Pesticide Use

Status:

Initial Medical Evaluation
Annual Review

Physical exertion while wearing respirator: Mild Moderate Strenuous

Maximum amount of time you wear a respirator in a single day: hours per day

Have you had the following problems while using a respirator? Yes No Yes No

No Eye irritation General weakness or fatigue

Skin allergies or rashes Other problem that interferes with respirator use

Anxiety If yes, please explain:

For Annual Review Only: Answer all questions. If you are unsure about conditions or symptoms, click name for details.

Have you ever had any of the following conditions and/or have you experienced any changes in the following conditions within the last 12 months.

1. Tobacco Usage	Yes	12 Mo.	No	7. Prescribed medications for respiratory or circulatory issues	Yes	12 Mo.	No
2. Seizures				8. Symptoms of cardiovascular or heart problems (chest pain)			
3. Diabetes				9. Cardiovascular or heart problems			
4. Allergic reactions in regards to breathing				10. Pulmonary or lung problems			
5. Claustrophobia (fear of closed-in places)				11. Symptoms of pulmonary or lung illness (coughing, shortness of breath, wheezing)			
6. Trouble smelling odors				12. Ruptured ear drum			
Heat exhaustion/heat stroke							

If answered "yes" to any question above, please explain in the corresponding medical questionnaire portion below. If answered "no" to all click [here](#) to sign and submit.

Medical Questionnaire

Tobacco Usage:

Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes No

If "yes", how many packs per day? 1/2 or less 1 2 2 or more

How many years have you smoked? 1-9 10-19 20-29 30+

Conditions: Have you ever had any of the following: Yes No Yes No If yes to any, please explain:

Seizures (fits)/Fainting Claustrophobia (fear of closed-in places)

Diabetes (sugar disease) Trouble smelling odors

Allergic reactions that interfere with your breathing Heat exhaustion or heat stroke

Trouble concentrating or remembering Ruptured ear drum

Medications:

Do you currently take medications for any of the following: Yes No Yes No

Breathing or lung problems Blood Pressure

Heart conditions Seizure (fits)

Cardiovascular or heart symptoms:

Have you ever had any of the following symptoms: Yes No Yes No

Frequent pain or tightness in your chest Skipping/missing heartbeat (in last 2 years)

Pain or tightness in your chest during physical activity Heartburn-like symptoms not related to eating

Pain or tightness in your chest that interferes with your job Any other heart/circulatory symptoms

Medical Questionnaire cont'd

Last Name: _____

UFID: _____

Cardiovascular or heart problems

Have you ever had any of the following problems:	Yes	No		Yes	No
Heart attack			Heart arrhythmia (heart beating irregularly)		
Stroke			High blood pressure		
Heart Failure			Any other heart problem that you've been told about		
Swelling in your legs not caused by walking			If yes, please explain:		

Pulmonary or lung problems:

Have you ever had any of the following conditions:	Yes	No		Yes	No
Asbestosis			Silicosis		
Asthma			Pneumothorax (collapsed lung)		
Chronic bronchitis			Broken ribs		
Emphysema			Any chest injuries or surgeries		
Pneumonia			Any other lung problem that you've been told about		
Tuberculosis			If yes, please explain:		

Pulmonary or lung illness symptoms:

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

Supplemental section for Full-Face piece or Self-Contained Breathing Apparatus (SCBA) users only (otherwise please skip & sign)

Do you currently:	Yes	No		Yes	No
Have vision loss (temporarily or permanently)			Have color blindness		
Wear glasses			Have difficulty hearing		
Wear contact lenses			Wear a hearing aid		
Have weakness in arms, hands, legs or feet			Have/had ear injury including broken ear drum		
Have difficulty fully moving arms and legs			Have difficulty fully moving your head up or down		
Have difficulty bending at your knees			Have difficulty fully moving your head side to side		
Have difficulty squatting to the ground			Pain/stiffness when leaning at waist (forward or backward)		
Climb stairs/ladder carrying more than 25 lbs.			Have back pain		
Have/had back injury			Any other muscle/skeletal/vision or hearing problems		

Additional Comments: _____

To the best of my knowledge, the information I have provided is true and accurate.

Employee Signature: _____ Date: _____

SUBMIT

if printing, please email to:
OccMedClinic-RiskAssessment@ahc.ufl.edu

TO BE COMPLETED BY THE EXAMINER/REVIEWER:

The mandatory questionnaire has been reviewed

This employee has been found to be physically able to use the following (check all that apply):

- | | |
|---|---|
| Single use, filter mask (four attachment points) | Full-faced powered cartridge-type (PAPR) |
| Half-faced cartridge-type, negative pressure | Self-contained breathing apparatus (SCBA) |
| Full-faced cartridge-type respirator, negative pressure | Hood/helmet powered cartridge-type (PAPR) |
| Half-faced powered cartridge-type (PAPR) | Half-faced/Full-faced/Hood/Helmet (NOT positive pressure) |

This respirator clearance expires in: 1 2 3 years from date indicated below.

Restrictions/Limitations for respirator use (if applicable): _____

There is insufficient information to make a determination at this time

This employee has been found to be physically NOT able to use a respirator

Reviewer's Name (print) _____

Reviewer's Signature _____

Date _____