

Name/UM Registration #

**Respirator Medical Evaluation Questionnaire - N95/PAPR (Respiratory Isolation Respirators)**

**Respirator Medical Re-Evaluation**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Employee ID#: \_\_\_\_\_ Job Title/Dept: \_\_\_\_\_

\*\*\* Are you scheduled for fit testing?  Yes  No If yes, when: \_\_\_\_\_

1. If you have worn a respirator in the past, have you had any problems wearing it?  Yes  No  
If yes, please explain: \_\_\_\_\_

2. Has your health changed since you last completed a health questionnaire to wear a respirator?  Yes  No  
If yes, please explain: \_\_\_\_\_

3. Do you have any medical problems that affect your breathing?  Yes  No  
If yes, please explain: \_\_\_\_\_

4. Are you aware of any allergies to artificial sweeteners?  Yes  No

5. Would you like to speak further with a health professional about wearing the respirator?  Yes  No  
If yes, please provide your e-mail and/or phone number so that we may contact you: \_\_\_\_\_

**ASSESSMENT – TO BE COMPLETED BY A CLINICAL PROVIDER IN THE OCCUPATIONAL HEALTH SERVICE**

- \_\_\_\_\_ Employee is cleared to perform job duties with use of a respirator
- \_\_\_\_\_ Employee notified to contact Occupational Health Service for further evaluation \_\_\_\_\_
- \_\_\_\_\_ Other recommendations: \_\_\_\_\_

It should be noted that medical qualification for respirator use is dependent upon proper fit testing and instruction regarding use and maintenance of respiratory equipment.

\_\_\_\_\_  
Clinician signature

\_\_\_\_\_  
Date