OCCUPATIONAL HEALTH SERVICES

Mail this and the attached registration and respirator forms using the enclosed envelope.

PART I – TO BE COMPLETED BY THE APPLICANT

Last Name: _____ First Name: _____ M.I._____

Date of Birth: ___/___/___ Gender: M / F SSN (**MANDATORY**) ☐☐☐-☐☐-☐☐☐☐

Department/Division: _____ Department contact (if known): _____

Job Title (House Officer, Fellow, Lecturer, etc): _____ Start date: _____

PART II -DOCUMENTED PROOF MUST BE ATTACHED WITH THIS FORM

Types of documentation required are:

___**Tetanus/Diphtheria/ Pertussis (Tdap):**
a. Documentation of Tdap vaccine - Td is not accepted.

___**Varicella: one of the following must be submitted:**
a. Signed physician's record documenting illness
b. Documentation of 2 doses of Varicella vaccine in the past
c. Laboratory report of immune titer

___**Measles (Rubeola) one of the following must be submitted:**
a. Physician's record documenting two (2) immunizations.
b. Laboratory report of immune antibody titer

___**Rubella: one of the following must be submitted:**
a. Physician's record documenting two (2) immunizations
b. Laboratory report of immune antibody titer

___**Mumps: one of the following must be submitted:**
a. Physician's record documenting two (2) immunizations
b. Laboratory report of immune antibody titer

___**Hepatitis B immunity:**
a. Three doses of Hepatitis B vaccine **AND** a positive titer after at least one month from the third vaccine
OR
b. Documentation of positive Hepatitis B antibody titer in the past.

___**Tuberculosis (TB) Screening:**
a. A PPD with negative results within the past 12 months
OR
b. For those with a history of a positive TST or treated TB in the past, results of chest xray or QFT laboratory documentation.

Please answer the following questions:

Do you have a latex allergy? _____ No _____ Yes

Smoking status: (check one) _____ I have never smoked _____ I quit smoking 6 months ago
_____ I want to quit smoking in the next 6 months _____ I smoke and do not want to quit

OCCUPATIONAL HEALTH SERVICES
C380 Med Inn Building; SPC 5838
Phone: (734) 764-8021 Fax: (734) 763-7405

Patient Registration Form

Name: (Last, First MI) _____ **Last 4 digits social security #**: _____

Street Address: _____

City: _____State: _____ **Zip**: _____

Phone number: home (_____) _____ cell (_____) _____

Date of Birth: _____/_____/_____ **Gender:** ❑ Male ❑ Female

Marital status (circle one): single married divorced life partner widowed

The US Department of Health and Human Services requires that we collect ethnicity and race to ensure equality care for all patients:

Ethnicity: Hispanic Non-Hispanic

Race:_____

Religion:_____

Parent name: _____ **Parent name:** _____

Emergency Contact

Name: _____ Phone Number: (_____) __ _____ Relationship: _____

Employment Information

Department: _____

Job Title: House officer I 2 3 4 5 6 7 (circle one)

Residency coordinator : _____

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Please fill in: Name/MRN

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

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employee: Do you need help reading or completing this form? (circle one): Yes/ No

***** Are you scheduled for fit testing?** ☐**Yes** ☐**No** **If yes, when:** _____

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.

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).*

Name: _____ Date: _____

Job Title: _____ Department / Unit: _____

Phone # *(where you can be reached by the health care professional who reviews this questionnaire)*:(_____)_____

Best time to reach you: _____ Age (to nearest year): _____ Sex: □ M □ F Height: _____ Weight: _____ lbs

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

2. Have you worn a respirator? ☐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 indicate ``yes'' or ``no'').*

** Are you aware of any allergies to artificial sweeteners? ☐Yes ☐No
   If yes, please explain: _____

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 (fits) ☐ Yes ☐ No
   b) Diabetes (sugar disease) ☐ 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

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

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

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

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

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 (fits) ☐ Yes ☐ No

If "yes," name the medications if you know them:_____

_____

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) ____
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

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? ☐ Yes ☐ No

ASSESSMENT – TO BE COMPLETED BY A NURSE OR PHYSICIAN 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.

_____ _____
Nurse or Physician signature Date