Name/UM Registration #

OCCUPATIONAL HEALTH SERVICES

healthy

C380 Med Inn, SPC 5838
Phone: (734) 764-8021
Fax: (734) 763-7405

Annual Respirator Screening:

Name: ______________________ Date: ______________________

Employee ID#: ______________ Job Title/Dept: ______________________

1. Have you worn a respirator in the past? .... ☐Yes ☐No

   If yes, have you had any problems wearing it? .... ☐Yes ☐No

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…. Are there any major changes since your last fit test? .... ☐Yes ☐No

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: ______________

X ______________
Employee Initials

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

_____ 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