RESPIRATOR USER SCREENING FORM

For initial and periodic screening of respirator users in conjunction with CSA Z94.4, Clause 12

PART 1: EMPLOYER INFORMATION

Employer name: Employer #:

Date:

Worksite address: Supervisor name: Email:

Telephone: ( ) Facsimile: ( )

PART 2: RESPIRATOR USER INFORMATION

Name: Employee #: Email:

Title/Occupation: Telephone: ( ) Facsimile: ( )

PART 3: CONDITIONS OF USE

ACTIVITIES requiring respirator use:

FREQUENCY of respirator use: ❑ Daily ❑ Weekly ❑ Monthly ❑ Yearly ❑ Other

EXERTION level during use: ❑ Light ❑ Moderate ❑ Heavy ❑ Other

DURATION of respirator use per shift: ❑ < 1/4 h ❑ > 1/4 h ❑ > 2 h ❑ Variable ❑ Other

TEMPERATURE during use: ❑ < 0° C ❑ > 0 and < 25° C ❑ > 25° C

ATMOSPHERIC PRESSURE during use: ❑ Reduced ❑ Normal/ambient ❑ Increased

SPECIAL WORK CONSIDERATIONS

Uncontrolled hostile environment:

❑ Emergency escape ❑ Firefighting ❑ Riot/Police activity ❑ Rescue operations

❑ IDLH

❑ Hazardous materials (emergency) ❑ Oxygen deficiency ❑ Confined spaces

❑ Other _____

Other personal protective equipment:

❑ Additional types of personal protective equipment required (specify): _____

❑ Estimated total weight of tools/equipment carried during respirator use: Maximum: _____ Average: _____

PART 4: TYPES OF RESPIRATORS USED (check all that apply)

❑ Tight-fitting ❑ Non-tight-fitting (e.g., hood) ❑ SCBA — open-circuit ❑ Mouth bit

❑ SCBA — closed-circuit ❑ Air-purifying, non-powered ❑ Airline, continuous-flow ❑ SCBA — escape

❑ Air-purifying, powered ❑ Airline, pressure-demand ❑ SCBA — closed-circuit escape

❑ Multi-functional pressure-demand/Airline with escape ❑ Supplied-air suit

❑ Combined airline with air-purifying elements ❑ Other (specify): _____

PART 5: RESPIRATOR USER'S HEALTH CONDITIONS

Check Yes or No box only. DO NOT specify **Note:** *Medical information is NOT to be offered on this form.*

(a) Some conditions can seriously affect your ability to safely use a respirator. Do you have or do you experience any of the following or any other condition that could affect respirator use? ❑ **Yes** ❑ **No**

Shortness of breath	Breathing difficulties	Chronic bronchitis	Emphysema
Lung disease	Chest pain on exertion	Heart problems	Allergies
Hypertension	Cardiovascular disease	Thyroid problems	Diabetes
Neuromuscular disease	Fainting spells	Dizziness/Nausea	Seizures
Temperature susceptibility	Claustrophobia/Fear of heights	Hearing impairment	Pacemaker
Panic attacks	Colour blindness	Asthma	
Vision impairment	Reduced sense of smell	Reduced sense of taste	
Back/Neck problems	Unusual facial features/Skin conditions	Dentures	

Other condition(s) affecting respirator use Prescription medication to control a condition

(b) Have you had previous difficulty while using a respirator? ❑ **Yes** ❑ **No**

(c) Do you have any concerns about your future ability to use a respirator safely? ❑ **Yes** ❑ **No**

A "YES" answer to (a), (b), or (c) indicates further assessment by a health care professional is required prior to respirator use.

Signature of respirator user: **Supervisor's initials:**

Date:

PART 6: HEALTH CARE PROFESSIONAL PRIMARY ASSESSMENT (if required)

Assessment date:

Respirator use permitted: ❑ Yes ❑ No ❑ Uncertain

Referred to medical assessment: ❑ Yes ❑ No

Comments:

Reassessment date:

Name of health care professional (HCP): Title: Signature of HCP:

PART 7: MEDICAL ASSESSMENT (if required)

Assessment date:

❑ Class 1. No restrictions

❑ Class 2. Some specific restrictions apply (specify): _____

❑ Class 3. Respirator use is NOT permitted.

Name of physician: Signature of physician: