**(Model SOP)**

**United States Army**

**Name of the Clinic**

**Occupational Health**

**(OFFICE SYMBOL) SOP No.\_\_\_\_\_\_**

**Effective Date\_\_\_\_\_**

**Date Removed from Service\_\_\_\_\_**

**RESPIRATORY PROTECTION PROGRAM –**

**MEDICAL ASSESSMENT FOR RESPIRATOR USE**

**1. PURPOSE**

To define the procedures for (name of clinic) in support of the Army Respiratory Protection Program at (name of post).

**2. AUTHORITY AND REGULATORY COMPLIANCE**

Federal, DoD, and Army regulations governing medical surveillance examinations are included below in the References section of this SOP.

**3. REFERENCES**

A. 29 CFR 1910.134, Respiratory Protection Standard, 8 Jan 1998

B. AR 11-34, Army Respiratory Program, 25 Jul, 2013

C. AR 40-5, Preventive Medicine, 25 May, 2007

D. DA PAM 40-11, Preventive Medicine, 22 Jul, 2005

E. TB MED 509, Spirometry in Occupational Health Surveillance, 24 Dec 1986

**4. ABBREVIATIONS / TERMS**

IH- Industrial Hygiene

OHC- Occupational Health Clinic

OHN-Occupational Health Nurse

OHP **-** Occupational Health Provider

OSHA - Occupational Safety and Health Administration

PFT - Pulmonary Function Test

PA - Physician Assistant

Respirator - A device designed to protect an individual’s respiratory system against harmful, irritating and /or nuisance materials present in the environment at concentrations exceeding those established by OSHA or for protection against an oxygen deficient atmosphere, or for an individual sensitivity.

**5. PROCEDURE**

1. Determination of Need for Respiratory Protection

The respiratory program manager, in conjunction with the appropriate Safety Officer and the Industrial Hygienist, determines the need for respiratory protective equipment based on the specific worksite hazard.

1. Medical Assessment for Respirator Use
2. Prior to wearing a respirator, a worker must be medically cleared and fit tested to wear the respirator chosen by the employer.
3. Medical clearance for respiratory use occurs annually or if there is medical status change with the worker affecting their use of a respirator.
4. Changes in health or facial contour (due to surgery, loss of teeth, loss of weight, and growth of facial hair) can occur over the course of a year and may affect the fit of a respirator even if earlier in the year the fit was appropriate.
5. An occupational health provider (an OHN or OHP) will approve the medical clearance for use of the required respirator. Required elements of a medical clearance exam include:

Required Elements

* 1. Medical History Form DD 2807-1, as indicated; completed with review by the OHN.
  2. OSHA Respirator Medical Evaluation Questionnaire

1. A follow-up exam by the OHP is required if a positive response is given to Questions 1-8 on the OSHA Respirator Medical Evaluation Questionnaire.
2. The OHP may evaluate, at their discretion, the medical issue affecting the worker’s ability to wear a respirator. Examples of tools that may be needed to evaluate a worker include medical tests, diagnostic tests (spirometry, blood pressure), and/or specialist consultation.
3. Spirometry or Pulmonary Function Test (PFT): PFT’s are recorded on DA FORM 5551-R (Spirometry Flow Sheet, see TB MED 509).
4. Clearance Notification:

The OHP provides a written recommendation regarding the employee’s ability to use the respirator to the employer.

1. Fit Testing for a Protective Mask or Respirator

The worker should have a fit test performed according to regulations by trained personnel. Once at the fit testing facility, the worker will complete their fit testing, have their protective mask / respirator issued (if applicable or on-site), and proper training on use and care of the respirator will be provided by authorized personnel.

**6. APPENDICES**

**Appendix A: OSHA Respirator Medical Evaluation Questionnaire**

**Appendix B: Sample Algorithm for Obtaining a Respirator**

**Appendix C: Sample Protective Mask/Respirator Request Form**

**Appendix D: Sample Protective Mask/Respirator Issue Card**

**Appendix A**

**OSHA Respirator Medical Evaluation Questionnaire**

(Adapted From 29 CFR 1910.134, Appendix C)

|  |
| --- |
|  |

|  |
| --- |
| **Respirator Medical Evaluation Questionnaire**   To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.   To the employee:   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).   1. Today's date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   2. Your name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   3. Your age (to nearest year):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   4. Sex (circle one): Male/Female   5. Your height: \_\_\_\_\_\_\_\_\_\_ ft. \_\_\_\_\_\_\_\_\_\_ in.   6. Your weight: \_\_\_\_\_\_\_\_\_\_\_\_ lbs.   7. Your job title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   9. The best time to phone you at this number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No   11. Check the type of respirator you will use (you can check more than one category): a. \_\_\_\_\_\_ N, R, or P disposable respirator (filter-mask, non-cartridge type only). b. \_\_\_\_\_\_ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).   12. Have you worn a respirator (circle one): 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 circle "yes" or "no").   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: 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   d. 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: Yes/No   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   Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.   10. Have you *ever lost* vision in either eye (temporarily or permanently): Yes/No   11. Do you *currently* have any of the following vision problems?   a. Wear contact lenses: Yes/No   b. Wear glasses: Yes/No   c. Color blind: Yes/No   d. Any other eye or vision problem: Yes/No   12. Have you *ever had* an injury to your ears, including a broken ear drum: Yes/No   13. Do you *currently* have any of the following hearing problems?   a. Difficulty hearing: Yes/No   b. Wear a hearing aid: Yes/No   c. Any other hearing or ear problem: Yes/No   14. Have you *ever had* a back injury: Yes/No   15. Do you *currently* have any of the following musculoskeletal problems?   a. Weakness in any of your arms, hands, legs, or feet: Yes/No   b. Back pain: Yes/No   c. Difficulty fully moving your arms and legs: Yes/No   d. Pain or stiffness when you lean forward or backward at the waist: Yes/No   e. Difficulty fully moving your head up or down: Yes/No   f. Difficulty fully moving your head side to side: Yes/No   g. Difficulty bending at your knees: Yes/No   h. Difficulty squatting to the ground: Yes/No   i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No   j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No   Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.   1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes/No   If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes/No   2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No   If "yes," name the chemicals if you know them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. Have you ever worked with any of the materials, or under any of the conditions, listed below:   a. Asbestos: Yes/No   b. Silica (*e.g.*, in sandblasting): Yes/No   c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No   d. Beryllium: Yes/No   e. Aluminum: Yes/No   f. Coal (for example, mining): Yes/No   g. Iron: Yes/No   h. Tin: Yes/No   i. Dusty environments: Yes/No   j. Any other hazardous exposures: Yes/No   If "yes," describe these exposures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   4. List any second jobs or side businesses you have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   5. List your previous occupations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   6. List your current and previous hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   7. Have you been in the military services? Yes/No   If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No   8. Have you ever worked on a HAZMAT team? Yes/No   9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes/No   If "yes," name the medications if you know them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   10. Will you be using any of the following items with your respirator(s)?   a. HEPA Filters: Yes/No   b. Canisters (for example, gas masks): Yes/No   c. Cartridges: Yes/No   11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:   a. Escape only (no rescue): Yes/No   b. Emergency rescue only: Yes/No   c. Less than 5 hours *per week:* Yes/No   d. Less than 2 hours *per day:* Yes/No   e. 2 to 4 hours per day: Yes/No   f. Over 4 hours per day: Yes/No   12. During the period you are using the respirator(s), is your work effort:   a. *Light* (less than 200 kcal per hour): Yes/No   If "yes," how long does this period last during the average shift:\_\_\_\_\_\_\_\_\_\_\_\_hrs.\_\_\_\_\_\_\_\_\_\_\_\_mins.   Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.   b. *Moderate* (200 to 350 kcal per hour): Yes/No   If "yes," how long does this period last during the average shift:\_\_\_\_\_\_\_\_\_\_\_\_hrs.\_\_\_\_\_\_\_\_\_\_\_\_mins.   Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or *pushing* a wheelbarrow with a heavy load (about 100 lbs.) on a level surface. c. *Heavy* (above 350 kcal per hour): Yes/No   If "yes," how long does this period last during the average shift:\_\_\_\_\_\_\_\_\_\_\_\_hrs.\_\_\_\_\_\_\_\_\_\_\_\_mins.   Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; *shoveling; standing* while bricklaying or chipping castings; *walking* up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).   13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No   If "yes," describe this protective clothing and/or equipment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No   15. Will you be working under humid conditions: Yes/No   16. Describe the work you'll be doing while you're using your respirator(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):  Name of the first toxic substance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Estimated maximum exposure level per shift:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration of exposure per shift:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of the second toxic substance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Estimated maximum exposure level per shift:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration of exposure per shift:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of the third toxic substance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Estimated maximum exposure level per shift:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration of exposure per shift:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ The name of any other toxic substances that you'll be exposed to while using your respirator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
|  |
|  |

**Appendix B**

**Sample Algorithm for Obtaining a Respirator**

Worker presents at the OHC for medical evaluation and clearance

If the worker is found to be unfit for respirator use for any reason, a written opinion will be submitted to the worker’s employer, the worker will be counseled, and the patient will be referred to their primary care provider

Worker is determined by OHC personnel to be fit for wearing the respirator

required for their job

Worker is given a copy of their Protective Mask/Respirator Request Formbefore leaving the OHC

The worker will take their copy of their Protective Mask/Respirator Request Form to the fit testing facility at Bldg. [X] as proof of clearing the medical evaluation at the OHC

Fit testing for recommended respirator performed on the worker

Worker is fit-tested, equipment is issued, and training and care of equipment is completed

The worker is issued a Protective Mask/Respirator Issue Card

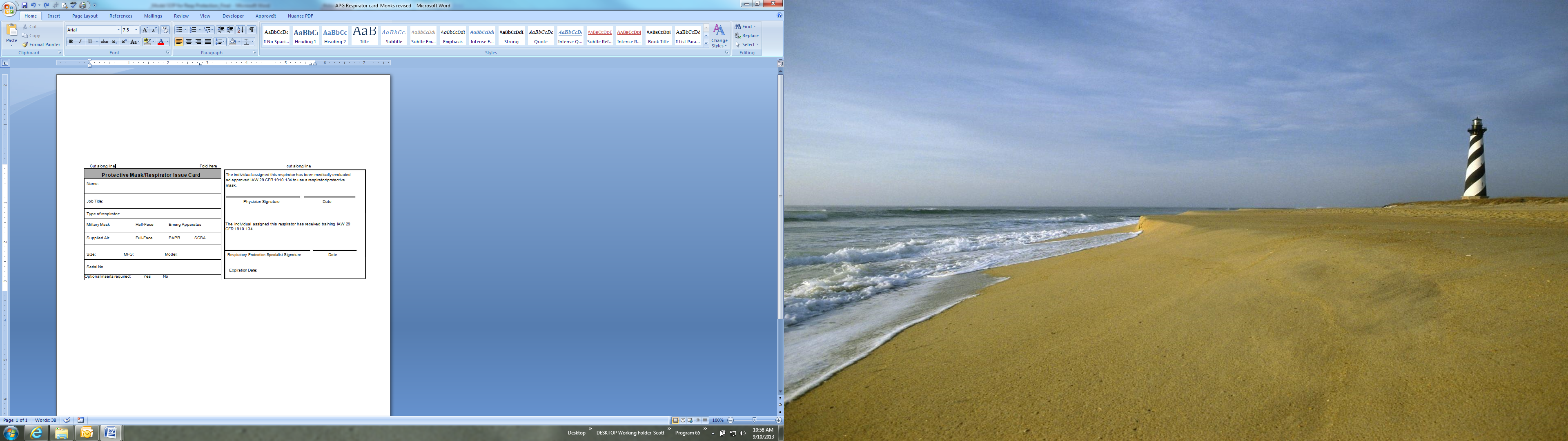
**Appendix C**

**Sample Protective Mask/Respirator Request Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PROTECTIVE MASK/RESPIRATOR REQUEST FORM** | | | | | | | | | | | | | | |
| **SECTION I – User Information** *(Completed by supervisor or sponsor)* | | | | | | | | | | | | | | |
| 1. Name of User: *(Print or Type*) | | | | | | 2. Social Security Number  \_\_\_ \_\_\_ \_\_\_ **-** \_\_\_ \_\_\_ **-** \_\_\_ \_\_\_ \_\_\_ \_\_\_ | | | | | | | | |
| Last Name | First Name | | | | MI |
| 3. Job Title and Series/MOS: | | | | 4. Phone  Number: | | | | | | | 5. Bldg  Number: | | | |
| 6. Organization: | | | | | | | | 7. Office  Symbol: | | | | | | |
| 8. Description/Type of work being done: | | | | | | | | | | | | | | |
| 9. List potential contaminants and their physical state: | | | | | | | | | | | | | | |
| 10. Additional protective clothing/equipment to be worn: | | | | | | | | | | | | | | |
| 11. Will mask/respirator be used for escape purposes only? *(Circle one)* Yes No | | | | | | | | | | | | | | |
| 12. Temperature extremes:  High\_\_\_\_\_\_\_\_\_ o F Low \_\_\_\_\_\_\_\_\_ o F | | | 13. Humidity extremes:  Low (0-39%) Medium (40-60%) High (61-100%) | | | | | | | | | | | |
| 14. Expected physical work effort:  Light Moderate Heavy | | 15. Hours per day expected to use respirator: | | | | | | | 16. Days per week expected to use respirator: | | | | | |
| 17. Printed name and signature of supervisor/sponsor | | | | | | | | | | 18. Date | | | | |
| **SECTION II – Industrial Hygiene Evaluation** *(Completed by the supporting Industrial Hygiene Office)* | | | | | | | | | | | | | | |
| 1. Assessment of exposure potential: | | | | | | | | | | | | | | |
| 2. Recommended protection:  **€** Military Mask  **€** Powered Air Purifying (PAPR) **€** Half-Face Air Purifying  **€** Self-Contained Breathing Apparatus (SCBA) **€** Full-Face Air Purifying  **€** Emergency Breathing Apparatus **€** Supplied Air | | | | | | | | | | | | | | |
| 3. Comments: | | | | | | | 4. Respirator considered voluntary use?  Yes No | | | | | | | |
| 5. Type of cartridge needed: | | | | | | | | | | | | | | |
| 6. Recommended cartridge change-out schedule: | | | | | | | | | | | | | | |
| 7. Printed name and signature of Industrial Hygienist: | | | | | | | | | | | | | 8. Date | |
| **SECTION III – Medical Information** *(Completed by Occupational Health)* | | | | | | | | | | | | | | |
| 1. Restrictions *(Check all that apply)*  **€** No restriction on respirator use **€** No respirator use is permitted **€** Optical inserts required  **€** Restriction – power air purifying respirator required (PAPR)  **€** Specific respirator use restrictions, as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| 2. Other comments: | | | | | | | | | | | | | | |
| 3. Printed name and signature of Physician | | | | | | | | | | | | 4. Date | | |
| **SECTION IV – User Authentication** *(Completed by User)* | | | | | | | | | | | | | | |
| Training Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I am aware that in addition to having received training and a respirator fit test by a competent individual, I must positively and negatively fit check my respirator prior to each use; report an improper fit, damage, or respirator defect to my supervisor/sponsor; and request a new fit test if there is any change in my facial configuration (e.g., weight loss/gain, surgery, etc.).  User’s signature Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| **Data Required by the Privacy Act of 1974 (5 U.S.C. 552a)** | | | | | | | | | | | | | |
| *Authority*: Title 29 Code of Federal Regulations, Part 1960.66(c) and Executive Order 12196  *Prescribing Directives*: Title 29 Code of Federal Regulations, Part 1910.134, AR 11-34, and (installation regulation)  *Principal Purpose*: Record and track mask and respirator users on APG to ensure accuracy and avoid duplication of records.  *Routine Uses*: Used by safety and occupational health personnel to record respirator and mask users. The social security number (SSN) is used to identify the individual to prevent possible duplication of respirator records, substantiation of medical clearance for equipment use, and correlate exposure data.  *Disclosure and Effect on Individual Not Providing This Information*: Disclosure is voluntary. However, since proper maintenance of medical records and statistical data is essential to successful compliance with these mandates, failure to provide the SSN may result in denial of respiratory protective equipment or result in it being obtained from other sources so as to ensure that all data being provided are accurately recorded and filed. | | | | | | | | | | | | | |

**Appendix D**

**Sample Respirator Issue Card**

****