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N95 RESPIRATOR USER INITIAL QUESTIONNAIRE

(USE THIS FORM FOR N95 USE IN COMPLIANCE WITH Cal/OSHA SECTION 5199 AEROSOL TRANSMISSABLE DISEASE STANDARD ONLY)

INSTRUCTIONS: Your supervisor must allow you to answer this questionnaire at a time and place that is convenient to you. To maintain your confidentiality. Please deliver, email, or FAX the completed form to STI, where it will be reviewed by compliance and kept in your confidential medical record.

Name (Last, First MI)		**Sex (M/F)**	**Date of Birth**	**Today's Date**
Employee ID#	**SUNet ID**	**E-Mail Address**		
Phone # where you can be reached		**Best time(s) to contact you at this number**		
Supervisor's Name		**Supervisor's E-Mail Address**		

A. MEDICAL HISTORY *(Employee completes)*

Please explain all 'Yes' answers below.

Yes	No	*Have you ever had any of the following conditions?*
☐	☐	Asthma or Reactive Airways Disease
☐	☐	Chronic Bronchitis or Emphysema
☐	☐	Pneumonia, Tuberculosis, or Pleurisy
☐	☐	Allergic reaction that interferes with your breathing
☐	☐	Allergic reaction to Bitrex (Denatonium benzoate)
☐	☐	Pneumothorax or broken ribs
☐	☐	High blood pressure
☐	☐	Heart attack or Stroke
☐	☐	Diabetes (sugar disease)
☐	☐	Seizures (epilepsy; "fits")
☐	☐	Cancer

Yes	No	*Do you currently have any of the following symptoms?*
☐	☐	Shortness of breath
☐	☐	Coughing up phlegm or blood
☐	☐	Wheezing
☐	☐	Chest pain or tightness
☐	☐	Irregular heart beat or arrhythmia
☐	☐	Trouble smelling odors
☐	☐	Claustrophobia or anxiety when wearing a respirator

☐	☐	Any other problem that may interfere with your use of a respirator

Explain all 'Yes' answers here:

What medications, if any, do you use for problems with your nose, sinuses, throat, lungs, breathing or heart function?

Would you like to speak with a health care professional about any of your answers to this questionnaire? ☐ **Yes** ☐ **No**

The preceding information is true to the best of my knowledge.

_____ _____

Employee's Signature **Date**

B. MEDICAL CLEARANCE *(Physician or other Licensed Health Care Provider completes)*

Medical Clearance for use of an N95 respirator in a clinical care setting:

☐ Approved ☐ Approved with restrictions ☐ Denied

Remarks:

Reviewed by:_____ _____

Clinician Name/Signature **Date**

CONFIDENTIAL WHEN COMPLETED