OSHA RESPIRATOR MEDICAL EVALUATION MANDATORY QUESTIONNAIRE

Fax to John Berzins, SCEMD at (803) 737-8570

Name: ___________________________________ SSN: _____________________________

Sex (circle one): Male / Female Height: ______ in. Weight : ______ lbs.

Age (to nearest year): __________ Job Title: ___________________________

Have worn a respirator before (circle one): Yes / No

If "yes", what type(s): ____

MANDATORY MEDICAL QUESTIONS

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month: Yes / No
   Pack history: _____________________________

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

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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 problems 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

8. If you've used a respirator, have you had any of the following problems? (If you've never used a respirator, 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. Have you ever lost vision in either eye (temporarily or permanently): Yes / No

10. 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

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11. Have you ever had an injury to your ears, including a broken eardrum? Yes / No

12. 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 problems: Yes / No

13. Have you ever had a back injury? Yes / No

14. 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 pounds: Yes / No

Student's Signature: ______________________________ Date: __________

This student has been screened per OSHA regulation 29 CFR 1910.134 for respirator use, and is medically cleared for fit testing.

Physician or Medical Officer Signature: ______________________________ Date: __________
(RN, PA, M.D. or Nurse Practitioner)

Sizing Sheet for (Name)___________________________

Circle the appropriate size in each category.
Fax to John Berzins, SCEMD at (803) 737-8570
For shoe size please indicate actual shoe size

SCBA MASK (if known)	small	medium	large	X-large	XX-large
JACKET	small	medium	large	X-large	XX-large
PANTS	small	medium	large	X-large	XX-large
GLOVES	small	medium	large	X-large	XX-large

SHOES M____________ W___________
(please indicate actual shoe size)

Student Information Sheet

Fill in the appropriate information.
Fax to John Berzins, SCEMD at (803) 737-8570.

Your Name: ____

Your Title: ____

Social Security Number: ____

Date of Birth: ____

Height: ___________________________ **Weight:** ____________________________

Hair Color: _______________________ **Eye Color:** __________________________

Organization You Are Representing: _______________________________________

Address: **Street:** ____

City: ____

State: ________________________ **Zip Code:** ________________

Home Phone: _______________________ **Work Phone:** _______________________

Email address: ____

Driver's License Number_________________________**State**______________________

Have you attended the ODP Course PER-222 Sampling Techniques and Guidelines____Yes _____No

Security Voucher Form

Fill in the appropriate information and have your supervisor sign it.
Fax toJohn Berzins, SCEMD at (803) 737-8570

1. The listed personnel are on official duty at US Army Dugway Proving Ground for training from __________________ **to** ________________ from _______________________________ (*e.g. San Antonio Fire Station xx, San Antonio, Texas)*. The class being attended is **ACBIRC**.

2. I understand that part of this training will include entry into a biological safety level 3 facility at the Life Sciences Division and work with vaccine strains of agents such as *Bacillus anthracis*, *Yersinia pestis* and *Francisella tularensis*.

3. Mr./Ms. ___________________________ has been with the department for _____ years during which time he/she has given no reason to question his/her loyalty to the department, the State of ___________, or the United States Government.

4. Insofar as I am able, I vouch for Mr./Ms. ______________________ in terms of security while he/she is participating in the training at US Army Dugway Proving Ground, Utah.

____
Supervisor's Name

____
Supervisor's Organization