

### PART 1: RESPIRATOR USER INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Staff ID #: \_\_\_\_\_ Job Title: \_\_\_\_\_  
 Department or School Facility: \_\_\_\_\_  
 Supervisor: \_\_\_\_\_ Date of Request: \_\_\_\_\_

### PART 2: CONDITIONS OF USE AND SPECIAL WORK CONSIDERATIONS

Activities requiring respirator use:

Frequency of respirator use:   Daily                   Weekly                   Monthly                   Yearly  
 Exertion level during use:    Light                   Moderate               Heavy

Duration of respirator use per shift:

                  Less than 15 minutes                   15 min- 2 hours                   Greater than 2 hours                   Varies

Temperature of work environment during use:   Less than 0°C                   0-25°C                   Greater than 25°C

Will other PPE (Personal Protective Equipment) be worn while wearing the respirator? :

          Yes                                   No  
 Safety Glasses                   Safety Goggles                   Hard Hat                   Hearing protection  
 Other (please specify): \_\_\_\_\_

### PART 3: TYPES OF RESPIRATORS USED

Check all that apply:    N95 Disposable                   Half Face-piece Elastomeric Respirator

### PART 4: RESPIRATOR USER'S HEALTH CONDITIONS

Review the list below. Check YES or NO only. Medical disclosure is NOT to be included 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	Dentures
Other conditions affecting respirator use	Prescription medication to control a condition (with side effect of sedation/ endurance/ concentration/ coordination impact)	Unusual facial features/ Skin conditions

- b) Have you had previous difficulty while using a respirator?      Yes      No
- c) Do you have any concerns about your ability to use a respirator?      Yes      No

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

Signature of Respirator User: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Supervisor: \_\_\_\_\_

### PART 5: HEALTH CARE PROFESSIONAL ASSESSMENT (IF REQUIRED)

Assessment Date: \_\_\_\_\_

- Respirator use permitted with no restrictions
- Respirator use is not permitted
- Respirator use permitted with specific restrictions

Specific restrictions: \_\_\_\_\_

Print Physician Name: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

*INFORMATION COLLECTION AUTHORIZATION:*

The personal information contained on this form has been collected under the authority of the Occupational Health and Safety Act, the Municipal Freedom of Information and Protection of Privacy Act, and the Personal Health Information Privacy Act, and will be used to assess ability to use respiratory protection. This form will be used by the Health and Safety Officer and retained for a two-year period. Questions pertaining to the collection of this information should be directed to the Superintendent of Human Resources.