

## Respirator User Screening Form

This form is intended for respirator user groups following the guidelines provided in CSA Z94.4-11 - Selection, use, and care of respirators.

### Part 1: Employer Information

Supervisor Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_ E-mail: \_\_\_\_\_

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

### Part 2: Employee Information

Name: \_\_\_\_\_ Occupation/Title: \_\_\_\_\_ Employee No.: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone No.: \_\_\_\_\_ Date of Request: \_\_\_\_\_

### Part 3: Conditions of Respirator Use

List activities requiring respirator use:

Frequency of use:  Daily  Weekly  Monthly  Yearly  Other

Duration of use (per shift):  <15 min.  >15 min.  >2 hours  Variable  Other

Exertion level during use:  Light  Moderate  Heavy  Other

Expected temperature during use:  <0 °C  >0 and <25 °C  >25 °C

### Part 4: Special Work Considerations for Respirator Use

Please select all environments that apply:  IDLH  Hazardous Materials  Confined Spaces  Oxygen Deficiency  Emergency Escape

List any additional PPE required:

Estimated weight of equipment carried during respirator use: Minimum: \_\_\_\_\_ Maximum: \_\_\_\_\_

### Part 5: Types of Respirators Used (check all that apply)

Tight Fitting  Air-purifying, powered  Air-purifying, non-powered  Supplied air suit  Other (specify): \_\_\_\_\_

### Part 6: Respirator User's Health Information

Underlying medical conditions can have adverse effects while using a respirator. Please indicate if you have experienced or have any of the following health conditions.

**Yes**, I have experienced or have at least one of the listed health conditions.  **No**, I have not experienced any of the listed health conditions.

Allergies

Asthma

Back/neck problems

Breathing difficulties

Cardiovascular disease

Chest pain on exertion

Chronic bronchitis

Claustrophobia/Fear of heights

Color blindness

Dentures

Diabetes

Dizziness/nausea

Emphysema

Fainting spells

Hearing impairment

Heart problems

Hypertension

Lung disease

Neuromuscular disease

Pacemaker

Panic attacks

Reduced sense of smell

Reduced sense of taste

Seizures

Shortness of breath

Temperature susceptibility

Thyroid problems

Unusual facial features

Unusual skin conditions

Vision impairment

Other condition(s) affecting respirator use:  Yes  No

Prescriptions used to control a condition:  Yes  No

Have you had previous difficulty while using a respirator?  Yes  No

Are you concerned with your ability to properly and safely use a respirator?  Yes  No

If you answered "Yes" to any questions in Part 6, an assessment by a health care professional is required prior to respirator use (Page 2).

**Signature of respirator user:** \_\_\_\_\_

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

**Signature of supervisor:** \_\_\_\_\_

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

## Respirator User Screening Form

---

### Part 7: Health Care Professional Assessment (if required)

---

Date of Assessment:

Respirator use permitted:  Yes  No  Uncertain

Referred to medical assessment:  Yes  No

Comments:

Reassessment date:

### Part 8: Medical Assessment (if required)

---

Date of Assessment:

- Class 1. No restrictions
- Class 2. Some specific restrictions apply (specify):
- Class 3. Respirator use is NOT permitted.

Name of Physician:

Signature of Physician: