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. *Note: Medical information is NOT to be offered on this form.*

☐ **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	Color blindness	Hypertension	Shortness of breath
Asthma	Dentures	Lung disease	Temperature susceptibility
Back/neck problems	Diabetes	Neuromuscular disease	Thyroid problems
Breathing difficulties	Dizziness/nausea	Pacemaker	Unusual facial features
Cardiovascular disease	Emphysema	Panic attacks	Unusual skin conditions
Chest pain on exertion	Fainting spells	Reduced sense of smell	Vision impairment
Chronic bronchitis	Hearing impairment	Reduced sense of taste	
Claustrophobia/Fear of heights	Heart problems	Seizures	

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: _____ **Signature of supervisor:** _____

Date: _____ **Date:** _____

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Part 7: 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:** _____