





Please Read This Page

These forms need to be opened in Adobe Reader or Adobe Acrobat to work properly. Do not open them in your internet browser. Failure to use Adobe may result in missing fields, missing signature blocks, or other issues.

Instructions:

Don't just click the file at the bottom of your browser (e.g. Google, Firefox, or Edge). This often opens the file inside the browser itself. The easiest way to ensure you are using Adobe is to browse to the download location on your computer and open the file from there.

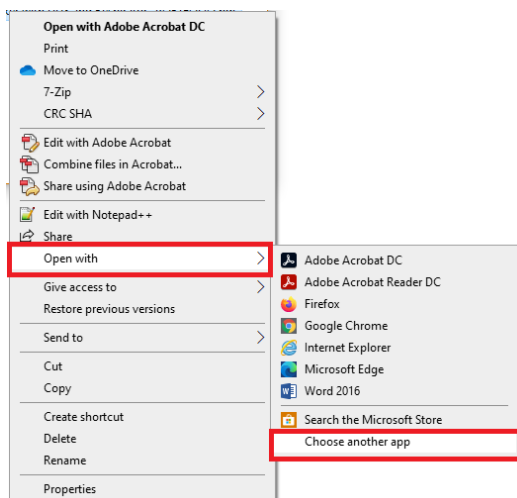
If you are using Windows, Adobe Reader is likely already installed on your computer. You can search for it in the start menu.  If you don't have Adobe Reader or Acrobat, download Reader and install it. It's quick and free, and can be downloaded here: <https://acrobat.adobe.com/us/en/acrobat/pdf-reader.html>.


Also, please note that browsers often try to take over your default file types too. If you see something other than the Adobe symbol () as your file's icon, it won't open in Adobe when you double-click it. You'll need to Right-Click the file and choose "Open with" and then select Adobe from the pop-up list. If Adobe isn't on the pop-up list, select "Choose another app" to find Adobe.

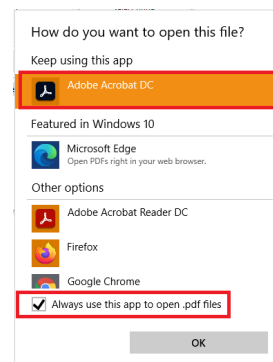
Optional: Setting the Default App for PDFs on Your Computer to Always Use Adobe

From your default download location on your computer, or wherever you saved the file, we can change the default app that will be used to open all PDFs on your computer. Here's how to do that:

- 1) Right-Click the PDF's file name
- 2) Choose "Open with"
- 3) Choose "Choose another app"



- 4) Make sure the "Always use this app to open .pdf files" box is checked **On**.
- 5) Select Adobe Reader or Adobe Acrobat from the list.
- 6) Press "OK". That's it! Your PDF icons will change to the Adobe symbol () and Adobe will now be your default PDF app.



Duke University Employee Occupational Health and Wellness QUESTIONNAIRE FOR RESPIRATOR USERS

*Employees who need respiratory protection against M. Tuberculosis, SARS,
Or other particulates found in clinical settings*

The Occupational Safety and Health Administration (OSHA) requires that the following information be provided by every employee who has been selected to use any type of respirator (please print). If you have any questions regarding the first two pages, you may call EOHW at 919-684-3136 Option #2.

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your supervisor must not look at or review your answers to the medical portion of this questionnaire. **When completed, this form should be sent as an attachment to EOHremote@dm.duke.edu.**

Can you read? Yes No

Today's Date: _____

Name: _____

Work Phone: _____

Duke ID: _____

Cell Phone : _____

Date of Birth: _____

Department: _____

Job Title: _____

Clinic Location: _____

Coordinator/Supervisor Name: _____

Sex: Male Female

Age: _____ Weight: _____ lbs.

Height: _____ ft. _____ in.

Check the type of respirator you will use in this job

Respirator types are pre checked for healthcare workers

PAPR or N-95

- | | |
|---|--|
| <input checked="" type="checkbox"/> N, R, or P disposable respirator (filter-mask, non-cartridge type only). (<1lb) | <input type="checkbox"/> supplied air, hood (<3 lbs) |
| <input type="checkbox"/> air-purifying, half mask (< 1 lb) | <input type="checkbox"/> supplied air, tight fitting (2 -4 lbs) |
| <input type="checkbox"/> air-purifying, full mask (1-3 lbs) | <input type="checkbox"/> Self-Contained Breathing Apparatus (SCBA) (24 lbs) |
| <input checked="" type="checkbox"/> powered air-purifying hood (<4 - 12 lbs) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> powered air-purifying, tight fitting (< 5 lbs) | Use is <input checked="" type="checkbox"/> Required <input type="checkbox"/> Voluntary |

Please indicate your level of work effort while using the respirator, indicating the amount of time you would spend at each level in a day: (Activity level pre-checked for the healthcare worker)

- | Level of Effort | Examples |
|--|--|
| <input type="checkbox"/> light _____ hours | Typing, operating a drill press. |
| <input checked="" type="checkbox"/> moderate _____ hours | Nailing, assembly work, pushing a wheelbarrow on a level surface |
| <input type="checkbox"/> heavy _____ hours | Heavy lifting, shoveling, climbing stairs with a heavy load |

How often do you expect to use the respirator?

- | | |
|---|---|
| <input type="checkbox"/> Respiratory Isolation Patients | <input type="checkbox"/> Daily, for less than 2 hours per day |
| <input type="checkbox"/> Emergency only | <input type="checkbox"/> Daily, for 2 - 4 hours per day |
| <input type="checkbox"/> Less than 5 hours per week | <input type="checkbox"/> Daily, more than 4 hours per day |

Have you worn a respirator in the past? Yes No

If yes, what type(s)? _____

Duke ID _____

Employee Name _____

On the list below, please check any types of personal protective equipment you will be wearing when using your respirator. (None) (PPE pre-checked for the healthcare worker)

- Gloves Hearing protection Apron or lab coat
- Eye protection Hard hat Full body suit PPE
- Any other PPE that will be worn: (Please describe) _____

Will you be working under hot conditions? (above 85 deg. F): Yes No

Will you be working under humid conditions? Yes No

Describe the work you will be doing while using your respirator(s):

- Care of respiratory isolation patients Other _____

Describe any special or hazardous conditions you might encounter when using your respirator(s) (for example, confined spaces, life-threatening gases):

_____ N/A _____

Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue or security):

Provide the following information, if known, for each potentially hazardous substance that you will be exposed to when using your respirator(s).

Name of potentially hazardous substance	Estimated Maximum Exposure Level	Duration of exposure (# hours/week)
Airborne M. Tuberculosis	Care of TB patient as necessary	Actual frequently not known
Airborne SARS pathogen		
Other airborne particulates		

Has your employer told you how to contact the health care professional who review this questionnaire? (Call Employee Health at 684-3136.) Yes No

For Employee Occupational Health Services (EOHS) use only:

Medically approved for All air-purifying respirators Supplied Air Respirators SCBA
 Other: _____

Restrictions: Employee may decline respirator-requiring assignments for temporary health-related difficulties
 Other: _____

Effective through _____ **OR** Complete brief questionnaire at time of annual training (Required users only)

Employee has been provided with a copy of this written recommendation: Yes No

Signature of Physician or Other Licensed Health Care Professional: _____

(Criteria: EE has health problems – Use medical judgment; No relevant health problems: indefinite clearance (20 years).)

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no").** Employee Occupational Health and Wellness (EOHW) at 684-3136 can assist you with this portion of the questionnaire.

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
1. Do you <u>currently</u> smoke tobacco, or have you smoked tobacco in the last month?	<input type="checkbox"/>	<input type="checkbox"/>	5. Do you <u>currently</u> have any of the following symptoms of pulmonary or lung illness?		
2. Have you <u>ever had</u> any of the following conditions?			a. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
a. Seizures (fits)	<input type="checkbox"/>	<input type="checkbox"/>	b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/>	<input type="checkbox"/>
b. Diabetes (sugar disease)	<input type="checkbox"/>	<input type="checkbox"/>	c. Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
c. Allergic reactions that interfere with your breathing	<input type="checkbox"/>	<input type="checkbox"/>	d. Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
d. Claustrophobia (fear of closed-in places)	<input type="checkbox"/>	<input type="checkbox"/>	e. Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>
e. Trouble smelling odors	<input type="checkbox"/>	<input type="checkbox"/>	f. Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
f. Heat stroke	<input type="checkbox"/>	<input type="checkbox"/>	g. Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you <u>ever had</u> any of the following pulmonary or lung problems?			h. Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>
a. Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>	i. Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	j. Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/>
c. Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	k. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
d. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	l. Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
e. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	m. Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/>
f. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	n. Any other symptoms that you think may be related to lung problems.	<input type="checkbox"/>	<input type="checkbox"/>
g. Silicosis	<input type="checkbox"/>	<input type="checkbox"/>			
h. Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>			
i. Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>			
j. Broken ribs	<input type="checkbox"/>	<input type="checkbox"/>			
k. Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/>			
l. Any other lung problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>			
4. Have you <u>ever had</u> any of the following cardiovascular or heart problems?					
a. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>			
b. Stroke	<input type="checkbox"/>	<input type="checkbox"/>			
c. Angina	<input type="checkbox"/>	<input type="checkbox"/>			
d. Heart failure	<input type="checkbox"/>	<input type="checkbox"/>			
e. Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/>	<input type="checkbox"/>			
f. Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/>	<input type="checkbox"/>			
g. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			
h. Any other heart problem that you've been told about.	<input type="checkbox"/>	<input type="checkbox"/>			

