

Program Subject: Respiratory Protection Policy

1 PURPOSE

- 1.1 To ensure that UW-Eau Claire has an effective respiratory protection program that is compliant with the Occupational Safety and Health Administration (OSHA) General Industry Standard 29 CFR 1910.134 "Respiratory Protection", and the (OSHA) Construction Standard 29 CFR 1926.103 "Respiratory Protection".
- 1.2 To that UW-Eau Claire faculty, staff, and students who use respiratory protection devices are:
 - 1.2.1 Provided with respiratory protection devices that are suitable for the tasks they perform;
 - 1.2.2 Medically able to wear these devices;
 - 1.2.3 Fit-tested to ensure proper fit;
 - 1.2.4 Trained in their use, maintenance and cleaning.
- 1.3 It is not only the intent of the employer to fully comply with applicable Environmental, Health and Safety (EH&S) standards and regulations, but also to maintain and improve the overall safety of University of Wisconsin-Eau Claire (UW-Eau Claire).

2 SCOPE

- 2.1 This policy applies to all UW-Eau Claire faculty, staff, and students who use a respirator as defined within this program. This program applies to all employees that are required to wear respirators during the completion of their duties.
- 2.2 This policy does not apply to third-party contractors while on UW-Eau Claire property. Contractors are responsible for their own Respiratory Protection Program (RPP) when working on UW-Eau Claire property. Contractor RPPs must conform to all applicable federal, state and local laws and regulations.
- 2.3 This policy includes safe practices and requirements to ensure protection from inhalation of particulate matter, toxic gases and vapors encountered on the job.
- 2.4 Respiratory protection will be used only where engineering or administrative controls are not feasible, cannot reduce exposure to acceptable levels, or while engineering controls are being installed.
- 2.5 The need for respiratory protection is dependent upon the type of operation, workplace conditions, and type and quantity of material(s) in use, or which may be breathed during the work process.
- 2.6 The use of respirators at UW-Eau Claire requires prior approval by the supervisor and is subject to the provisions of this policy.
- 2.7 This policy provides guidelines for: determining the need for a respiratory, medical evaluation required and the proper respirator selection, fitting and use of required equipment, and maintenance and care of respirator.

Program Subject: Respiratory Protection Policy

3 DEFINITION

- 3.1 **Air-Purifying Respirator** = A respirator with an air-purifying filter, cartridge, or canister capable of removing specific air contaminants by passing ambient air through the air-purifying element.
- 3.2 **Dust Mask** = A mask that is not designed as a filtering face piece and is not certified by NIOSH for use as a respirator.
- 3.3 **Fit Test** = A qualitative or quantitative evaluation of the air seal between the respirator and an individual's face.
- 3.4 **Full-Face Respirator** = A facepiece that covers from roughly the hairline to below the chin. On average they provide the greatest protection, usually seal most reliably, and provide some eye protection.
- 3.5 **Half-Face Respirator** = A facepiece that fits over the nose and under the chin and does not protect the eyes.
- 3.6 **Immediately Dangerous to Life or Health (IDLH)** = Any atmosphere that poses an immediate hazard to life or poses immediate irreversible debilitating effects on health.
- 3.7 **Negative Pressure Respirator** = A respirator in which the air pressure inside the facepiece inlet covering is negative during inhalation with respect to the ambient air pressure.
- 3.8 **Negative-Pressure (User Seal) Check** - Close off the inlet opening of the canister or cartridge(s) by covering with the palm of the hand(s) or by replacing the filter seal(s), inhale gently so that the facepiece collapses slightly, and hold the breath for ten seconds. See section 5.5.8(a)
- 3.9 **Positive pressure respirator** = A respirator in which the pressure inside the respiratory inlet covering is normally positive with respect to ambient air pressure.
- 3.10 **Positive-Pressure (User Seal) Check** - Block the exhaust port with the heel of your hand and exhale with enough force to cause a slight positive pressure inside the face-piece. If the face-piece bulges slightly and no air leaks between the face and face-piece are detected, a proper fit has been obtained. See section 5.5.8(b).
- 3.11 **Powered Air-Purifying Respirator (PAPR)** = An air-purifying respirator that uses a blower to force ambient air through an air-purifying cartridge or filter and into the facepiece.
- 3.12 **Qualitative Fit Test (QLFT)** = A pass/fail evaluation of the seal between the respirator and the individual's face that relies on the individual's ability for sensory response to detect a challenge agent (e.g., sweet taste).
- 3.13 **Quantitative Fit Test (QNFT)** = A pass/fail evaluation of the seal between the respirator and the individual's face that used an instrument to measure the differential between a level of a challenge agent.
- 3.14 **Respirator Cartridge** = A container with a filter, sorbent medium, or combination of these items that removes specific contaminants (particulates, gases, and/or vapors) from air passed through the container.
- 3.15 **User Seal Check** = A self-test conducted by a respirator user to determine if a respirator is properly seated to the face prior to its use in the workplace.

Program Subject: Respiratory Protection Policy

4 RESPONSIBILITIES

4.1 Department of “Risk Management and Safety” (RM&S)

- 4.1.1 Responsible for the development and implementation of this policy.
- 4.1.2 Provide necessary resources to carry out the program.
- 4.1.3 Evaluate and ensure adequacy of respiratory protection equipment before the purchase and issuance to individuals.
- 4.1.4 Provide instruction on the need for respiratory protection; criteria for selecting and respirator fitting, use and maintenance.
- 4.1.5 Conduct annual fit tests for employees who utilize respiratory equipment.
- 4.1.6 Ensure employees who are required to wear a respirator undergo a medical evaluation. See section 5.3 Medical Evaluation Procedures.
- 4.1.7 Assist in selecting respiratory protection devices that are appropriate for a specific job or task. See section 5.9 Selection of Respirators.
- 4.1.8 Conduct annual training for proper respirator usage, maintenance, and storage.
- 4.1.9 Maintain records of all medical authorizations for use of respirators, fit testing and training on file.

4.2 Supervisors

- 4.2.1 Recognize conditions and products that might present a respiratory health hazard.
- 4.2.2 Identify job procedures that their employees are engaged in which might make them subject to the requirements of respiratory protection.
- 4.2.3 Before the proper respirator can be selected for a job, a supervisor must:
 - 4.2.3.1 Identify the respiratory hazard (Part 1, **Appendix D**)
 - 4.2.3.2 Evaluate the workplace hazard (See **Appendix D. Hazard Assessment for Respirator Use**).
 - 4.2.3.3 Completed the respirator selection form and selected based on respiratory hazards worker is exposed. (See **Appendix A. Respirator Request Form**).
 - 4.2.3.4 Order the appropriate respirator to protect the employee.
- 4.2.4 Request assistance from RM&S in evaluating existing, new or changed work processes that may include respiratory health and safety hazards.
- 4.2.5 Schedule medical exams for their employees who will be required to wear a respirator in the performance of their duties and for those who met the criteria in section 5.3 Medical Evaluation Procedures.
- 4.2.6 Provide the employee with respirator medical approval form found in (**Appendix C**) and medical questionnaire form found in (**Appendix E**) to take with to the Physician or Licensed Health Care Professional (PLHCP).
- 4.2.7 Schedule fit-testing with RM&S each time an employee receives a new respirator.
- 4.2.8 Enforce the provisions of this policy and other requirements which may be applicable, with regards to use of respirators by employees.

Program Subject: Respiratory Protection Policy

4.3 Employees

- 4.3.1 Utilize the issued respiratory protection equipment in accordance with instruction and training provided by RM&S.
- 4.3.2 Inform his/her supervisor if the respirator no longer fits well and if any personal health problems exist that could be aggravated by wearing respiratory equipment.
- 4.3.3 Guard against damage and ensure respirators are not disassembled, modified, or altered in any way other than by replacing respirator cartridges/filters.
- 4.3.4 Attend annual fit testing and training.
- 4.3.5 Inspect respirators for defects or missing parts monthly and before each use.
- 4.3.6 Clean and store respirator in a clean sanitary location. See section 5.10.4 Storage.

5 PROGRAM COMPONENTS

5.1 Respiratory Hazard Assessment

- 5.1.1 Shop supervisor may request (RM&S) to conduct Respiratory Hazard Assessments, as necessary to identify potential respiratory risks or hazards that employees may be exposed to. (See **Appendix D. Hazard Assessment for Respirator Use**).
- 5.1.2 The Respiratory Hazard Assessment shall:
 - a. Identify the respiratory hazard(s) in the workplace;
 - b. Include a reasonable estimate of employee exposure to the respiratory hazard(s);
 - c. Identify the contaminant's chemical state and physical form.
- 5.1.3 A respiratory Hazard Assessment must be completed for all areas and procedures approved for use of respirators.
- 5.1.4 Where the facility cannot identify or reasonably estimate the employee exposure, the atmosphere shall be considered an immediately dangerous to life or health (IDLH).
- 5.1.5 Employees are engaged in activities that are addressed in other (EH&S) policies such as asbestos, certain other chemical, biological, or radiological hazards, or for confined space entry, which require the use of respiratory protection.

5.2 Respirator Use Requirements

The use of required respiratory protection program at UW-Eau Claire campus is limited to those situations where a documented need to utilize such equipment exists, employees who maintain an appropriate medical evaluation, and complete annual fit testing.

5.2.1 Documentation of Respirator Needs

- a. Respirators are only to be used in situations where engineering controls are infeasible or during installation of such controls.

Program Subject: Respiratory Protection Policy

5.3 Medical Evaluation Procedures

- 5.3.1 Employees who are required to wear respiratory protection shall have a medical evaluation from a physician in accordance with OSHA Guidelines and procedures.
- 5.3.2 Employees are not permitted to wear respirators until a physician has determined that they are medically able to do so.
- 5.3.3 Employees will not be allowed to work in an area requiring a respirator until the employee has passed their medical evaluation and have successfully completed respirator fit testing.
- 5.3.4 All UWEC employees will be medically evaluated by a physician, or other licensed healthcare professional (PLHCP) within the Occupational Medicine Department at Mayo Clinic Health System, 733 W. Clairemont Ave., Eau Claire.
- 5.3.5 Risk Management & Safety will use a medical questionnaire found in (**Appendix E. Respirator User Medical Questionnaire**).
- 5.3.6 All affected employees will be given a copy of the medical questionnaire to fill out and they will bring the completed questionnaire to the medical practitioner.
- 5.3.7 All medical questionnaires and examinations are confidential and handled during the employee's normal working hours or at a time and place convenient to the employee.
- 5.3.8 All employees will be granted the opportunity to speak with the medical practitioner about their medical evaluation, if they so request.
Note: All examinations and questionnaires are to remain confidential between the employee and the physician.
- 5.3.9 Medical evaluations conducted by a licensed physician shall be required initially and at least annually pursuant when:
 - a. An employee reports medical signs or symptoms that are related to ability to use a respirator, such as shortness of breath, dizziness, chest pains, or wheezing.
 - b. A physician or other licensed health care professional, supervisor or representative from Risk Management & Safety informs the employer that an employee needs to be reevaluated.
 - c. Information from the respiratory protection program including observations made during fit testing and program evaluation indicates a need for employee reevaluation. (See **Appendix B. Qualitative respirator fit test**)
 - d. A change occurs in workplace conditions (e.g., physical work effort, protective clothing, and temperature) that may result in a substantial increase in the physiological burden placed on an employee.
- 5.3.10 Records of Medical Evaluations shall be maintained by Risk Management & Safety, in the office of the Risk Management & Safety Specialist Senior.

Program Subject: Respiratory Protection Policy

- 5.4 Medical Determination of the employee's ability to use a respirator.
- 5.4.1 The employee needs to complete Part 1 of the form.
 - 5.4.2 Physician or (PLHCP) needs to complete Part 2 of the form.
 - 5.4.3 Physician shall indicate on the form the need, if any, for follow-up medical evaluation.
 - 5.4.4 The employee shall provide the (RM&S) with the completed Employee Respirator Medical Approval Form (**Appendix C. Employee Respirator Medical Approval Form**) and the provider medical examination report.
 - 5.4.5 If the physician finds a medical condition that may place the employee's health at increased risk if using an Air Purifying Respirator, then (RM&S) shall provide a Powered Air Purifying Respirator (PAPR), if the physician approved.
 - 5.4.6 If a subsequent medical evaluation finds that the employee is medically able to use a negative pressure respirator, then the PAPR is no longer required.
- 5.5 Fit-Testing
- 5.5.1 Fit-Testing is essential to ensure that a respirator forms a good seal with the wearer's face. This prevents contaminants from leaking into the mask.
 - 5.5.2 When the employee is authorized to wear a respirator, the immediate supervisor shall contact the manufacturer to purchase a respirator based on the completed Respirator Selection Form (**Appendix E. Respirator User Medical Questionnaire**) by the (RM&S).
 - 5.5.3 All tight-fitting respirators, including Self-Contained Breathing Apparatus (SCBA), must be fit tested to determine proper fit.
 - 5.5.4 Fit-test after the medical evaluation is performed and medical approval is received.
 - 5.5.5 Fit-test prior to initial use of a respirator with a positive or negative pressure tight fitting face-piece. It is required to have fit-testing at least annually.
 - 5.5.6 Fit-test whenever a different respirator is used (size, style, model, or make).
 - 5.5.7 Fit-test whenever there are changes to the employee's physical condition that could affect the fit. This include facial scarring, dental changes, cosmetic surgery, and obvious change in body weight.
 - 5.5.8 The employee shall be provided the opportunity to wear the respirator in normal air for an adequate familiarity period. The following fit checks shall be conducted each time a tight-fitting respirator is used:
 - a. Negative Pressure Test
 - ✓ The user closes off the inlet of the cartridges or filters by covering with the palms so it does not allow air to pass; inhales gently so the face piece collapses slightly; and holds his/her breath for about 10 seconds. If a vacuum and partial inward collapse of the mask cannot be maintained for a least 10 seconds, readjust the mask and try again.
 - ✓ If the face piece remains slightly collapsed and no inward leakage is detected, the respirator probably fits tightly enough. This test of course, can only be used on respirators with tight fitting face pieces. It also has potential drawbacks, such as the hand pressure modifying the face piece seal and causing false results.

Program Subject: Respiratory Protection Policy

- b. Positive Pressure Test
 - ✓ The wearer closes off the exhalation valve and exhaling gently into the face piece. The respirator fit is considered okay if slight positive pressure can be built up inside the face piece without any evidence of outward leakage around the face piece. In addition, the wearer should be careful not to exhale too strongly so as not to force leakage.
- 5.6 Prior to Fit-Testing
 - 5.6.1 The employee should be shown how to put on respirator, how to position the respirator on their face, how to set the strap tension and how to determine an acceptable fit.
 - 5.6.2 The employee should be informed that he/she is being asked to select the respirator that provides the most acceptable fit. Employees should be instructed to let us know if the respirator fit is unacceptable.
 - 5.6.3 The employee should be allowed to wear the respirator for at least 5 minutes to assess comfort prior to fit-testing.
 - 5.6.4 The comfort of the respirator should be assessed by reviewing the following with the employee:
 - a. Position of the mask on the nose
 - b. Room for eye protection
 - c. Room to talk
 - d. Position of mask on face and cheeks
 - 5.6.5 The fit of the respirator should be assessed by observing the following:
 - a. Chin properly placed and fit across nose bridge
 - b. Adequate strap tension, not overly tightened
 - c. Respirator proper size to span distance between nose to chin
 - d. Tendency of respirator to slip
 - e. Employee observation of respirator fit in mirror if possible
- 5.7 Fit-Testing Procedures (See **Appendix B. Qualitative Respirator Fit Test**). It will be performed in the following manner:
 - 5.7.1 Employees will be required to demonstrate ability to put on and properly adjust respirator.
 - 5.7.2 They will conduct a negative pressure check to verify a good facial seal by blocking the air flow through the respirator filter during inhalation. Ambient air leakage into the respirator around the face seal indicates an improper fit.
 - 5.7.3 The employee is exposed to an atmosphere containing an irritating aerosol and then asked to perform several exercises to challenge the respirator fit. The wearer reports any noticeable irritation caused by mask leaks.

Program Subject: Respiratory Protection Policy

- 5.7.4 If the employee does not detect the smoke, proceed with the fit-test exercises. The smoke should be directed around the mask at distance of 6 inches. These will include:
- Normal Breathing (NB): In normal standing position, without talking, the subject shall breathe normally for at least one minute.
 - Deep Breathing (DB): In normal standing position, the subject performs deep breathing for at least one minute, pausing so as not to hyperventilate.
 - Turning Head Side to Side (SS): Standing up, the subject shall slowly turn his/her head from side to side between the extreme positions to each side. The head shall be held at each extreme position for at least 5 seconds.
 - Moving Head Up and Down (UD): Standing up, the subject shall slowly move his/her head up and down between the extreme position straight up and the extreme position for at least 5 seconds.
 - Talking (T): The subject shall talk out loud slowly and loud enough to be heard clearly by the test conductor. The subject can read from a prepared text such as the Rainbow Passage, or count backward from 100.
 - Bending Over (BO): The test subject shall bend at the waist as if he/she was to touch his/her toes.
 - Normal Breathing (NB): Same as the first exercise.
- 5.7.5 If the employee detects smoke during the test, stop immediately and have them adjust their respirator in another area.
- 5.8 Authorization for use of respiratory protection equipment
- 5.8.1 Only those employees who are required to utilize respiratory protection equipment by the provisions of this policy and who have been properly fitted and trained in its use, shall utilize respirators.
- 5.8.2 Employees who have been designated to wear respirators with tight-fitting face pieces shall not have:
- Facial hair that comes between the sealing surface of the face piece and the face or that interferes with valve function.
 - Any condition that interferes with the face-to-face piece seal or valve-function.
- 5.9 Selection of Respirators (See **Appendix A. Respirator Request Form**)
- 5.9.1 No respirators shall be purchased or used except as authorized by the terms and conditions of this policy.
- 5.9.2 Only respirators appropriate for the intended use certified by National Institute for Occupational safety and Health (NIOSH) shall be selected and these must be used in compliance with the conditions of the certification and manufacturer use instructions.
- Respirator parts which are not certified for use together must never be interchanged.
 - Respirator parts manufactured by different respirator suppliers must never be interchanged.

Program Subject: Respiratory Protection Policy

- 5.9.3 Respirators shall be selected based on the potential hazard to which the worker is exposed. The following factors must be considered in making this selection.
- The appropriate respirator will be based on the respiratory hazard(s) to which the employee is exposed and workplace and user factors that affect respirator performance and reliability.
 - The identity of the substance(s) and environment for which protection is needed
 - The respirators must be selected from models and sizes so that it is acceptable to, and correctly fits the user.
 - Any limitations or restrictions applicable to the types of respirators being considered which could make them unsafe in the work environment involved.
- 5.9.4 Respirators selected shall be adequate to protect the health of the employee and ensure compliance with all other OSHA regulatory requirements under routine and reasonably foreseeable emergency situations.
- 5.9.5 No respirator shall be used for any purpose unless the “Respirator Request Form” for that application has been completed. (See **Appendix A. Respirator Request Form**)
- 5.10 Maintenance and Care of Respirators: The primary responsibility for maintaining the respirator in proper and clean condition rests with the employee. The maintenance and care of respirator shall include:
- 5.10.1 Monthly Visual Inspection: The shop/department will appoint a responsible person(s) to conduct an inspection of each department personnel’s respirator and verify completion by initialing and dating an inspection tag mounted on the side of the respirator box.
- To ensure all parts are inspected for dirt, residue, pliability of rubber, deterioration and cracks, tears, and holes.
 - To ensure the valves are checked for holes, warp age, cracks, and dirt.
 - To check hoods, helmets, and face shields for cracks, tears, and distortions.
- 5.10.2 Cleaning and disinfecting: Each employee issued a respirator is responsible for maintaining the equipment and make sure it is free of defects. Cleaning should be done on a regular basis or after each day’s use.
- The face pieces are removed from the receptacles and are disassembled.
 - Remove filter and straps.
 - All parts are washed in warm soap water and visible residue is removed with a brush.
 - The parts are rinsed in clean water and allowed to air-dry.
 - Wipe the respirator with disinfectant wipes to kill germs.
- 5.10.3 Repair: Respirator users should ensure their equipment is in working order by periodically checking the equipment for the following defects:
- Snap fasteners on headbands and on face piece that are worn, distorted, or loose.
 - Plastic exhalation valve seat that is distorted or contains scratches or cracks on its sealing surface.
 - Exhalation valve cover that is distorted or decomposed

Program Subject: Respiratory Protection Policy

- d. If any of the above defects are found, the respirator should be turned in for the immediate attention of the supervisor.
- e. If immediate repairs cannot be made and a respirator is needed, a temporary replacement with the same model and size, and a new respirator shall be issued.
- f. Exchange of parts from one brand to another is NOT ALLOWED. Use only cartridges, filters and replacement parts specified from each respirator.

5.10.4 Storage

- a. Respirators are to be cleaned according to manufacturer's instructions and inspected.
- b. All respirators should be stored in plastic bag, and then placed in a proper storage cabinet in a non-hazard area.
- c. All respirators shall be stored in a manner that protects them from damage, dust, sunlight, extreme temperatures, excessive moisture, or damaging chemicals.
- d. Emergency respirators shall be kept accessible to the work area.
- e. The devices should be stored in a normal position.

5.11 Voluntary Use of Respirators

5.11.1 Conditions of Voluntary Use.

- a. If there is no hazard and respirator use is voluntary, (RM&S) shall not be required to provide the respirator.
- b. The employee making voluntary use of a respirator is responsible for obtaining and documenting all necessary medical examinations and fit-testing.
- c. Voluntarily worn respirator must not in itself create a health hazard and must be appropriate for the intended use and certified by the (NIOSH).
- d. Most of voluntary use situations involve filtering face pieces which are provided for the worker's sense of comfort.

5.11.2 Voluntary Use Responsibilities

- a. Read and pay attention to all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warning regarding the respirators limitations.
- b. See that the voluntary respirator is cleaned, stored, and maintained so that its use does not present a health hazard to the user or other employees.
- c. Do not wear your respirator in atmospheres containing contaminants for which your respirator is not designed to protect against. For example, a respirator designed to filter dust particles will not protect against gases, vapors, or very small solid particles of fumes or smoke.
- d. Keep track of your respirator so that you do not mistakenly use someone else's respirator.

Program Subject: Respiratory Protection Policy

6 TRAINING

- 6.1 Each employee designated to wear a respirator must receive adequate training.
- 6.2 Training shall be provided prior to requiring the employee to wear a respirator in the workplace and annually thereafter.
- 6.3 Training shall ensure that each employee can demonstrate knowledge of the following:
 - 6.3.1 Why the respirator is necessary and how improper fit, usage, or maintenance can compromise the protective effects of the respirator.
 - 6.3.2 Limitations and capabilities of the respirator.
 - 6.3.3 How to use the respirator effectively in emergency situations, including situations in which the respirator malfunctions.
 - 6.3.4 How to inspect, put on, remove, use, and check the seals of the respirator.
 - 6.3.5 What the procedures are for maintenance and storage of the respirator.
 - 6.3.6 How to recognize medical signs and symptoms that may limit or prevent the effective use of respirators.
 - 6.3.7 The general requirements of 29 CFR 1910.134.
- 6.4 Retraining is required at least annually and when the following situations occur:
 - 6.4.1. Changes in the workplace or the type of respirator render previous training obsolete.
 - 6.4.2. Inadequacies in the employee's knowledge or use of the respirator indicate that the employee has not retained the requisite understanding or skill.
 - 6.4.3. Any other situation arises in which retraining appears necessary to ensure safe respirator use.

7. RECORD KEEPING

- 7.1 The Risk Management & Safety shall establish and maintain an accurate record for each employee subject to the Program. This record shall include:
 - 7.1.1 The medical evaluation form and any physician's written opinion, including results of medical examination, opinions and recommendations.
 - 7.1.2 Employees who are trained in respirator use, have annually fit-testing, and have documentation of the care and maintenance of respirators

Program Subject: Respiratory Protection Policy

APPENDIX A. Respirator Request Form

A. REQUEST FOR EMPLOYEE RESPIRATOR ASSIGNMENT

Employee Name: _____ Date of Birth: _____ Phone: _____
 Dept.: _____ Location: _____ Supervisor: _____
 Type of Hazards: _____

B. SELECTION

Model size of Respirator: _____ Weight of Respirator: _____
 Level of work effort (circle one) Light Moderate Heavy Strenuous

Equipment Selection

Face-piece: N95 MASK OTHER: _____

Respirator Types: AIR-PURIFYING RESPIRATOR (APR) – HALF MASK POWER AIR-PURIFYING RESPIRATOR (PAPR)

Cartridge(s): HEPA (Purple) _____ P100 Multi-purpose (Olive) Acid Gas (White)
 Ammonia/Amine (Green) Organic Vapor (Black) Mercury/Chlorine (Orange)
 Organic Vapor/Acid Gas (Yellow) Other: _____

Form of Contaminants: Lead Dust Asbestos Dust Smoke Gas Fumes Vapor
 (Check all that apply) Spray Paint Aerosol Chemical Spill Clean-up Hazardous Materials

Area or Operation: _____ Chemical substance(s) involved: _____
 Physical state of contaminant: _____ Permissible exposure limit: _____

Any changes in the operations that might significantly increase anticipated containment level: YES NO

Date of measurement(s): _____ Contaminant is absorbed through skin _____ Eye Irritant _____

Is environment immediately dangerous to life or health? YES NO Any oxygen deficiency? YES NO

Extent of usage (circle one)

1. On daily basis
2. Occasionally – but more than once a week
3. Rarely – or for emergency situations only
4. Less than once a month
5. 2-5 times a month.

Length of time of anticipated effort in hours: _____

Name special work conditions (i.e., oxygen deficiency, temperature, hazardous material, protective clothing, etc.): _____

C. FITTING

1. Type of respirator: _____ Date of Fit-Test: _____

2. In the past year, have you had a chance to do fit-testing? YES NO

D. EMPLOYEE ACKNOWLEDGMENT

I have received training in respiratory protection, qualitative fit testing, and the proper care of my respirator(s). I am aware of the limitations of the above respirator(s) and I will only wear the one(s) that is/are issued to me. I must attend the training and fitting annually if I have a respirator in my possession.

Employee Signature: _____ Review by supervisor: _____ Date: _____

Review by Risk Management & Safety: _____ Date: _____

Program Subject: Respiratory Protection Policy

APPENDIX B. QUALITATIVE RESPIRATOR FIT-TEST

GENERAL INFORMATION

Employee Name (Print):		Department:		Tester:	
Employee's Job Title:			Date of Fit-Test:		Expiration Date:
<input type="checkbox"/> YES <input type="checkbox"/> NO Any medical signs or symptoms that are related to your ability to use a respirator.					
<input type="checkbox"/> YES <input type="checkbox"/> NO A change occurs in your workplace conditions. i.e. physical work effort, protective clothing, temperature.					
Type of Test:			Respirator Used For:		
<input type="checkbox"/> Irritant Smoke <input type="checkbox"/> Isoamyl Acetate		<input type="checkbox"/> Saccharin Solution <input type="checkbox"/> Bitrex		<input type="checkbox"/> Asbestos <input type="checkbox"/> Lead <input type="checkbox"/> Painting <input type="checkbox"/> Other: _____	
RESPIRATOR INFORMATION					
Manufacturer:		Model No.:		Size (if applicable):	
TEST INFORMATION (check PASS, FAIL, or Not Applicable for each item)					
TEST	P	F	NA	REMARKS	
Sensitivity check					
Successful positive/negative pressure fit checks?					
Subject instructed to keep eyes closed during test?					
Hair growth between skin and face piece sealing surface?					
<input type="checkbox"/> Clean Shaven					
<input type="checkbox"/> 1 - 2 Day Beard Growth					
<input type="checkbox"/> 1 - 2 Day Moustache Growth					
Subject having any difficulty breathing?					
Normal breathing (1minute)					
Deep breathing (1 minute)					
Turning head side to side (1 minute)					
Moving head up and down (1minute)					
Talking (recite Rainbow Passage)					
Bending over, touching toes (1 minute)					
Normal breathing (1 minute)					
ADDITIONAL COMMENTS:					
Test Conductor: _____			Date: _____		
Employee's Signature: _____			Date: _____		
Note: Pass: P; Fail: F; Not Applicable: NA					

Program Subject: Respiratory Protection Policy

APPENDIX C. Employee Respirator Medical Approval Form

Part 1. To be completed by employee (Please Print).

Employee's Name: _____ Job Title: _____ Date of Birth: _____

Department: _____ Supervisor's Name: _____ Today's Date: _____

Activities requiring respirator use: _____

Form of Contaminants: Lead Dust Asbestos Dust Smoke Gas Fumes Vapor
(Check all that apply) Spray Paint Aerosol Chemical Spill Clean-up Hazardous Materials

Check the type of respirator to be used: Air-purifying Respirator (APR) Half Face

Power Air-purifying Respirator (PAPR) Full Face Self-Contained Breathing Apparatus (SCBA)

Part 2. To be completed by Physician or Licensed Health Care Professional

Medical Evaluator Contact Information:

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

PHYSICIAN'S EVALUATION

CLASS: (Please Check)

Class 1: No Restrictions on respirator use for this employee.

Class 2: Some specific use restriction for this employee. (See comments restriction below)

Class 3: No respirator use permitted for this employee.

Class 4: Other. Please specify: _____

Restrictions: _____

A re-evaluation for respirator use at any earlier interval may be required if any of the conditions in 29 CFR 1910.134(e)(7) occur.

Physician's Name (please print)

Physician Signature

Date

Note: This form must be completed and a copy presented to Risk Management & Safety Specialist Senior before an employee will be fit-tested for a respirator and trained.

Program Subject: Respiratory Protection Policy

APPENDIX D. Hazard Assessment for Respirator Use

Employee's Name: _____ Job Title: _____

Supervisor Name: _____ Signature: _____

Department: _____ Phone #: _____ Date: _____

Location: _____

PART 1. Hazard Identification:

1. Air contaminant identification (by chemical name): _____
2. Engineering controls? YES NO EXPLAIN: _____
3. Administrative Controls? YES NO EXPLAIN: _____
4. Another PPE? YES NO EXPLAIN: _____
5. Work description/Operation: _____
6. Characteristics of Work Area: _____
7. Anticipated Respirator Use Time (hours/day): _____

PART 2. Hazard Assessment:

1. Immediately Dangerous to Life and Health (IDLH) YES NO EXPLAIN: _____
2. Oxygen Content: Below 19.5% YES NO Ambient YES NO Above 21.5% YES NO
3. Air Contaminant Type: GAS/VAPOR PARTICULATE (LEAD & ASBESTOS) AEROSOL SPRAY PAINT
4. If particulate, is there oil mist present? NO OIL OIL POSSIBLE OIL PRESENT
5. Warning Properties? YES NO EXPLAIN: _____
6. What are the warning signs of this contaminant (eye irritation, smell, etc.)? YES NO
 EXPLAIN: _____
7. What are potential health effects from exposure to this contaminant?
 - a. Acute: _____
 - b. Chronic: _____
 - c. Target organs: _____
8. What type(s) of respirators can the employee wear to protect himself from the identified hazards?
N95MASK AIR-PURIFYING RESPIRATOR (APR) HALF MASK POWER AIR-PURIFYING RESPIRATOR (PAPR)
SELF-CONTAINED BREATHING APPARATUS (SCBA)

 Risk Assessor (print name) Signature Assessment Date

 Review by Supervisor Signature Date

 Review by RM&S Staff Signature Date



Program Subject: Respiratory Protection Policy

APPENDIX E. Respirator User Medical Questionnaire

This questionnaire will be used in determining whether you have a medical condition that may affect your ability to wear a respirator. All medical information is considered confidential.

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee: 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 employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or sent this questionnaire to the "Occupational Health Care Professional" (OHCP) who will review it.

OSHA Part A. Section 1. (Mandatory): The following information must be provided by every employee who has been selected to use any type of respirator. **Please print.**

Name:	DOB:	Age:	Today's Date:
Sex: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Height: ft. in.	Weight: lbs.	Your Job Title:
A phone number where you can be reached by the (OHCP) who reviews this questionnaire (include the Area Code):			
The best time to phone you at this number:			
Has your employer told you how to contact the (OHCP) who will review this questionnaire (check one): <input type="checkbox"/> YES <input type="checkbox"/> NO			
Check the type of respirator you will use (you can check more than one category):			
a. <input type="checkbox"/> N, R, or P disposable respirator (filter-mask, non-cartridge type only)			
b. <input type="checkbox"/> Other Type: <input type="checkbox"/> Half-face type <input type="checkbox"/> Full-facepiece type <input type="checkbox"/> Supplied air <input type="checkbox"/> Powered air-purifying respirator (PAPR) with hood <input type="checkbox"/> Powered air-purifying respirator (PAPR) with facepiece <input type="checkbox"/> Self-contained breathing apparatus (SCBA)			
Have you worn a respirator before? <input type="checkbox"/> YES <input type="checkbox"/> NO			
o If "YES", what type(s)? (not brand name):			

OSHA Part A. Section 2. (Mandatory): Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check "NO or YES"). If "YES", check on "NOW or PAST".

NO.	Medical Questionnaires	NO	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
1.	Do you currently smoke tobacco, or have you smoked in the last month?	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
2.	Have you ever had any of the following conditions?		
	a. Seizures?	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	b. Diabetes (sugar disease)?	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	c. Allergic reactions that interfere with your breathing?	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	d. Claustrophobia (fear of closed-in places)?	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	e. Trouble smelling odors?	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
3.	Have you ever had any of the following pulmonary or lung problems?		
	a. Asbestosis	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	b. Asthma	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	c. Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	d. Emphysema	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	e. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	f. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	g. Silicosis	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	h. Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	i. Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST

Program Subject: Respiratory Protection Policy

	j. Broken Ribs	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	k. Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	l. Any other lung problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
4.	Do you currently have any of the following symptoms of pulmonary or lung illness?		
	a. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	c. Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	d. Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	e. Shortness of breath when washing/dressing yourself	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	f. Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	g. Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	h. Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	i. Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	j. Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	k. Wheezing	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	l. Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	m. Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	n. Any other symptoms that you think may be related to lung problems	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
5.	Have you ever had any of the following cardiovascular or heart problems?		
	a. Heart attack	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	b. Stroke	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	c. Angina	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	d. Heart failure	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	e. Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	f. Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	g. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	h. Any other heart problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
6.	Have you ever had any of the following cardiovascular or heart symptoms?		
	a. Frequent pain or tightness in your chest	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	b. Pain or tightness in your chest during physical activity	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	c. Pain or tightness in your chest that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	d. In the past two years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	e. Heartburn or indigestion that is not related to eating	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	f. Any other symptom you think may be related to heart or circulation problems	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
7.	Do you currently take medication for any of the following problems?		
	a. Breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	b. Heart trouble	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	c. Blood pressure	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	d. Seizures	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
8.	If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check here: <input type="checkbox"/> and go on to question 9.)		
	a. Eye irritation	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	b. Skin allergies or rashes	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	c. Anxiety	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	d. General weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	e. Any other problem that interferes with your use of a respirator	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST

Program Subject: Respiratory Protection Policy

9.	Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire? If yes, call Mayo Clinic Health System at (715)838-5279.	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
<p>Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.</p>			
10.	Have you ever lost vision in either eye (temporarily or permanently)?	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
11.	Do you currently have any of the following vision problems?		
	a. Wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	b. Wear glasses	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	c. Color blind	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	d. Any other eye or vision problem	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
12.	Have you ever had an injury to your ears, including a broken ear drum?	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
13.	Do you currently have any of the following hearing problems?		
	a. Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	b. Wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	c. Any other hearing or ear problem	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
14.	Have you ever had a back injury?	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
15.	Do you currently have any of the following musculoskeletal problems?		
	a. Weakness in any of your arms, hands, legs, or feet	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	b. Back pain	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	c. Difficulty fully moving your arms and legs	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	d. Pain and stiffness when you lean forward or backward at the waist	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	e. Difficulty fully moving your head up or down	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	b. Difficulty fully moving your head side to side	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	g. Difficulty bending at your knees	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	h. Difficulty squatting to the ground	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST
	j. Any other muscle or skeletal problem that interferes with using a respirator	<input type="checkbox"/>	<input type="checkbox"/> YES: <input type="checkbox"/> NOW <input type="checkbox"/> PAST

VERIFICATION / CONSENT STATEMENT

I verify that the information I provided in this medical history is true and complete to the best of my knowledge. I understand that this evaluation is designed to satisfy regulatory requirements and should not be considered to be a routine medical examination. ***“Further, I agree to self-report to my supervisor changes in my medical condition that might affect my ability to work safely in a respirator”.***

 Printed Full Name

 Signature

 Date

Occupational Health Care Professional (OHCP) Use Only

(OHCP) Provider Comments:

Respirator Questionnaire Reviewed By:

 OHCP Provider (Printed)

 Signature

 Date