Loyalist College
Respirator User Screening Form

Part 1: Respirator User Information

Name: ____________________
Position: ____________________
Department/Program: ____________________
Supervisor: ____________________

Part 2: Conditions of Use

Activities requiring respirator use: ____________________

Frequency of respirator use: ☐ daily ☐ weekly ☐ monthly ☐ yearly ☐ rarely ☐ uncertain

Exertion level during use: ☐ light ☐ moderate ☐ heavy

Duration of respirator use/shift: ☐ <1/4 hr ☐ 1/4 - 2 hr ☐ >2hr ☐ variable ☐ unknown

Temperature during use: ☐ <0°C ☐ >0 to<25°C ☐ >25°C

Part 3: Work Considerations

Environment in which the respirator will be used: ____________________

☐ Type 1 Asbestos operations
☐ Type 2 Asbestos operations
☐ Confined spaces
☐ Oxygen deficiency
☐ Hazardous materials (emergency)
☐ Infection control (against airborne droplets)

Additional types of personal protective equipment required: ____________________

Estimated total weight of tools/equipment carried during respirator use: __________ ☐ kg ☐ lb

Part 4: Types of Respirators Used (check all that apply)

☐ Tight fitting - half face
☐ Non-tight fitting (e.g. hood)
☐ Air purifying - non powered
☐ Tight fitting – full face
☐ SCBA
☐ Air purifying – powered
☐ N95 Particulate Respirator

____________________ (Signature of Supervisor/Program Coordinator)

____________________ (Date)

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Part 5: Respirator User's Health Conditions (check YES or NO box only. Do not offer specific medical information 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 another condition that may affect respirator use?
☐ YES ☐ NO

Shortness of breath	Breathing difficulties	Chronic bronchitis	Emphysema
Lung disease	Chest pain on exertion	Cardiovascular disease	Neuromuscular disease
Hypertension	Back/neck problems	Heart problems	Diabetes
Thyroid problems	Fainting spells	Dizziness/Nausea	Temperature susceptibility
Seizures	Claustrophobia	Reduced sense of smell	Reduced sense of taste
Panic attacks	Colour blindness	Asthma Dentures	Pacemaker
Vision impairment	Hearing impairment	Allergies (List:) ______	
Facial features/skin conditions	Prescription medicine to control a condition	Allergic reactions that interfered with breathing:	☐ YES ☐ NO

Other condition(s) affecting respirator use: ______________________

b) Have you had previous difficulty while using a respirator? ☐ YES ☐ NO ☐ Never Worn

c) Do you have any concerns about your future ability to use a respirator safely? ☐ YES ☐ NO

If you answered YES to a), b) or c), a further assessment by a health care professional may be required.

______________________ (Signature of respirator user) ______________________ (Date)

Part 6: Primary Assessment

Respirator use permitted? ☐ YES ☐ NO ☐ Uncertain

Referred for Medical Assessment? ☐ YES ☐ NO

Comments: ______________________

______________ (Name – print) ______________ (Signature of Fit Tester) ______________ (Date of Assessment)

Part 7: Medical Assessment (if required)

☐ NO restrictions to respirator use

☐ Some specific restrictions apply: ______________________

☐ Respirator use is NOT permitted: ______________________

Comments: ______________________

______________ (Name of Physician) ______________ (Signature of Physician) ______________ (Date of Assessment)