Appendix C to § 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

PLEASE FILL IN THE REQUIRED FIELDS THAT ARE MARKED *

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:**

Can you read: ◯ Yes | ◯ No

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 de or send this questionnaire to the healthcare professional who will review it.

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).

*Today's date: _____ mm/dd/year

*First Name: _____

*Last Name: _____

*Age(to nearest year) _____

*Sex
◯ Male
◯ Female

*Height: _____ ft. _____ in.

*Weight: _____ lbs.

*Job title: _____

*A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____ ex.999-999-9999

*The best time to phone you at this number _____ ex.12:00pm

*Has your employer told you how to contact the health care professional who will review this questionnaire ◯ Yes | ◯ No

***Check the type of respirator you will use (you can check more than one category):**

☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

☐ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

*Have you worn a respirator ◯ Yes | ◯ No If "yes," what type(s) _____

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