GRANITE GUY

(508) 460-7900

**RESPIRATOR MEDICAL EVALUATION FORM**

*For employees who are required by the company to wear some type of respirator. The employee is required to fill this out during work hours , they will keep the information secure until the pre-arranged date/time/location listed on the last page of this form or enclosed envelop. On that date they will bring this completed form to the medical provider so they can be examined to wear a respirator.*

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).

| | |
|---|---|
| **1. Today's date:** | |
| **2. Your Full Name** | |
| **3. Your Age** | |
| **4. Your Sex** | |
| **5. Your Height** | |
| **6. Your Weight (lbs)** | |
| **7. Your Job Title:** | Granite/Synthetic stone grinder/polisher |
| **8. Phone to be called at if needed:** | (508) 460-7900 |
| **9. Best time to call you** | 7am - 3pm |

**10.**

| | | |
|---|---|---|
| **Has your employer told you how to contact the health care professional who will review this questionnaire** | ☑ YES | ☐ NO |

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

| | |
|---|---|
| N, R, or P rated disposable filtering facepiece aka dust mask with exhale port. | ☑ |
| Half face (mouth, nose) negative air cartridge respirator | ☑ |
| Full face (mouth, nose, eyes) negative air cartridge respirator | ☐ |
| Powered Air Purifying full face cartridge respirator (PAPR) | ☐ |
| Supplied airline full face respirator | ☐ |
| Self-Contained Breathing apparatus (SCBA) | ☐ |

**12.**

| | | |
|---|---|---|
| **Have you worn a respirator before ?** | ☐ YES | ☐ NO |

GRANITE GUY

**RESPIRATOR MEDICAL EVALUATION FORM**

| | |
|---|---|
| If yes, please tell us which type of respirator you have used. | Dusk masks N-95 / N-100 |

***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 "yes" or "no").***

1.

| | | |
|---|---|---|
| Do you *currently* smoke tobacco, or have you smoked tobacco in the last month ? | ☐ YES | ☐ NO |

2. Have you *ever had* any of the following conditions?

| | | |
|---|---|---|
| a. Seizures: | ☐ YES | ☐ NO |
| b. Diabetes (sugar disease): | ☐ YES | ☐ NO |
| c. Allergic reactions that interfere with your breathing: | ☐ YES | ☐ NO |
| d. Claustrophobia (fear of closed-in places) | ☐ YES | ☐ NO |
| e. Trouble smelling odors: Yes/No | ☐ YES | ☐ NO |

3. Have you *ever had* any of the following pulmonary or lung problems?

| | | |
|---|---|---|
| a. Asbestosis: | ☐ YES | ☐ NO |
| b. Asthma: | ☐ YES | ☐ NO |
| c. Chronic bronchitis: | ☐ YES | ☐ NO |
| d. Emphysema: | ☐ YES | ☐ NO |
| e. Pneumonia: | ☐ YES | ☐ NO |
| f. Tuberculosis: | ☐ YES | ☐ NO |
| g. Silicosis: | ☐ YES | ☐ NO |
| h. Pneumothorax (collapsed lung): | ☐ YES | ☐ NO |
| i. Lung cancer: | ☐ YES | ☐ NO |
| j. Broken ribs: | ☐ YES | ☐ NO |
| k. Any chest injuries or surgeries: | ☐ YES | ☐ NO |
| l. Any other lung problem that you've been told about | ☐ YES | ☐ NO |

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?

**RESPIRATOR MEDICAL EVALUATION FORM**

| | | |
|---|---|---|
| a. Shortness of breath: | ☐ YES | ☐ NO |
| b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: | ☐ YES | ☐ NO |
| c. Shortness of breath when walking with other people at an ordinary pace on level ground: | ☐ YES | ☐ NO |
| d. Have to stop for breath when walking at your own pace on level ground: | ☐ YES | ☐ NO |
| e. Shortness of breath when washing or dressing yourself: | ☐ YES | ☐ NO |
| f. Shortness of breath that interferes with your job: | ☐ YES | ☐ NO |
| g. Coughing that produces phlegm (thick sputum): | ☐ YES | ☐ NO |
| h. Coughing that wakes you early in the morning: | ☐ YES | ☐ NO |
| i. Coughing that occurs mostly when you are lying down: | ☐ YES | ☐ NO |
| j. Coughing up blood in the last month: | ☐ YES | ☐ NO |
| k. Wheezing: | ☐ YES | ☐ NO |
| l. Wheezing that interferes with your job: | ☐ YES | ☐ NO |
| m. Chest pain when you breathe deeply: | ☐ YES | ☐ NO |
| n. Any other symptoms that you think may be related to lung problems: | ☐ YES | ☐ NO |

5. Have you *ever had* any of the following cardiovascular or heart problems?

| | | |
|---|---|---|
| a. Heart attack: | ☐ YES | ☐ NO |
| b. Stroke: | ☐ YES | ☐ NO |
| c. Angina: | ☐ YES | ☐ NO |
| d. Heart failure | ☐ YES | ☐ NO |
| e. Swelling in your legs or feet (not caused by walking | ☐ YES | ☐ NO |
| f. Heart arrhythmia (heart beating irregularly): | ☐ YES | ☐ NO |
| g. High blood pressure: | ☐ YES | ☐ NO |
| h. Any other heart problem that you've been told about: | ☐ YES | ☐ NO |

6. Have you *ever had* any of the following cardiovascular or heart symptoms?

**RESPIRATOR MEDICAL EVALUATION FORM**

| | | |
|---|---|---|
| a. Frequent pain or tightness in your chest: | ☐ YES | ☐ NO |
| b. Pain or tightness in your chest during physical activity: | ☐ YES | ☐ NO |
| c. Pain or tightness in your chest that interferes with your job: | ☐ YES | ☐ NO |
| d. In the past 2 years, have you noticed your heart skipping or missing a beat: | ☐ YES | ☐ NO |
| e. Heartburn or indigestion that is not related to eating: | ☐ YES | ☐ NO |
| d. Any other symptoms that you think may be related to heart or circulation problems: | ☐ YES | ☐ NO |

7. Do you *currently* take medication for any of the following problems?

| | | |
|---|---|---|
| a. Breathing or lung problems: | ☐ YES | ☐ NO |
| b. Heart trouble: | ☐ YES | ☐ NO |
| c. Blood pressure: | ☐ YES | ☐ NO |
| d. Seizures: | ☐ YES | ☐ NO |

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check off "N/A" and go to question 9)

| | | |
|---|---|---|
| a. Eye irritation: | ☐ YES | ☐ NO |
| b. Skin allergies or rashes: | ☐ YES | ☐ NO |
| c. Anxiety: | ☐ YES | ☐ NO |
| d. General weakness or fatigue: | ☐ YES | ☐ NO |
| e. Any other problem that interferes with your use of a respirator: | ☐ YES | ☐ NO |
| Not Applicable(N/A) ☐ | | |

9.

| | | |
|---|---|---|
| Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? | ☐ YES | ☐ NO |

***Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.***

**RESPIRATOR MEDICAL EVALUATION FORM**

10.

| | | |
|---|---|---|
| Have you *ever lost* vision in either eye (temporarily or permanently): | ☐ YES | ☐ NO |

11. Do you *currently* have any of the following vision problems?

| | | |
|---|---|---|
| a. Wear contact lenses: | ☐ YES | ☐ NO |
| b. Wear glasses: | ☐ YES | ☐ NO |
| c. Color blind: | ☐ YES | ☐ NO |
| d. Any other eye or vision problem | ☐ YES | ☐ NO |

12.

| | | |
|---|---|---|
| Have you *ever had* an injury to your ears, including a broken ear drum: | ☐ YES | ☐ NO |

13. Do you *currently* have any of the following hearing problems?

| | | |
|---|---|---|
| a. Difficulty hearing: | ☐ YES | ☐ NO |
| b. Wear hearing aid: | ☐ YES | ☐ NO |
| c. Any other hearing problem: | ☐ YES | ☐ NO |

14.

| | | |
|---|---|---|
| Have you *ever had* a back injury: | ☐ YES | ☐ NO |

15. Do you *currently* have any of the following musculoskeletal problems?

| | | |
|---|---|---|
| a. Weakness in any of your arms, hands, legs, or feet: | ☐ YES | ☐ NO |
| b. Back Pain: | ☐ YES | ☐ NO |
| c. Difficulty moving your arms and legs: | ☐ YES | ☐ NO |

**RESPIRATOR MEDICAL EVALUATION FORM**

| | | |
|---|---|---|
| d. Pain/stiffness when leaning forward/backward at the waist: | ☐ YES | ☐ NO |
| e. Difficulty fully moving your head up or down: | ☐ YES | ☐ NO |
| f. Difficulty fully moving your head side to side: | ☐ YES | ☐ NO |
| g. Difficulty bending at your knees: | ☐ YES | ☐ NO |
| h. Difficulty squatting to the ground: | ☐ YES | ☐ NO |
| i. Climbing a flight of stairs or a ladder carrying more than 25 lbs | ☐ YES | ☐ NO |
| j. Any other muscle or skeletal problem which interferes with using a respirator. | ☐ YES | ☐ NO |

***Part B Any of the following questions, and other questions that are not listed here may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.***

1.

| | | |
|---|---|---|
| In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: | ☐ YES | ☑ NO |
| If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: | ☐ YES | ☐ NO |

2.

| | | |
|---|---|---|
| At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: | ☐ YES | ☐ NO |
| If "yes," name the chemicals if you know them: | | |

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

| | | |
|---|---|---|
| a. Weakness in any of your arms, hands, legs, or feet: | ☐ YES | ☐ NO |
| b. Back Pain: | ☐ YES | ☐ NO |
| c. Difficulty moving your arms and legs: | ☐ YES | ☐ NO |
| | | |

**RESPIRATOR MEDICAL EVALUATION FORM**

| | | |
|---|---|---|
| d. Pain/stiffness when you lean forward/backward at the waist | ☐ YES | ☐ NO |
| e. Difficulty fully moving your head up or down: | ☐ YES | ☐ NO |
| f. Difficulty fully moving your head side to side: | ☐ YES | ☐ NO |
| g. Difficulty bending at your knees: | ☐ YES | ☐ NO |
| h. Difficulty squatting to the ground: | ☐ YES | ☐ NO |
| ii. Climbing a flight of stairs or a ladder carrying more than 25 lbs | ☐ YES | ☐ NO |
| j. Any other muscle or skeletal problem which interferes with using a respirator. | ☐ YES | ☐ NO |
| If you answered "yes," to any of these, describe these exposure(s): | | |

4.

| | |
|---|---|
| List any second jobs or side businesses you have: | |

5.

| | |
|---|---|
| List your previous occupation(s) if different from work now: | |

6.

| | |
|---|---|
| List your current & previous hobby(s): | |

7.

| | | |
|---|---|---|
| Have you been in the military services? | ☐ YES | ☐ NO |
| If "yes," were you exposed to biological or chemical agents (either in training or combat): | ☐ YES | ☐ NO |

8.

| | | |
|---|---|---|
| Have you ever worked on a hazmat team ? | ☐ YES | ☐ NO |

9.

| | | |
|---|---|---|
| Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): | ☐ YES | ☐ NO |
| If "yes," name the medication(s) if you know them: | | |

**RESPIRATOR MEDICAL EVALUATION FORM**

10. Will you be using any of the following items with your respirator(s)?:

| | | |
|---|---|---|
| a. HEPA Filtering facepieces/dustmasks with exhale ports: | ☑ YES | ☐ NO |
| b. Canisters (for example, gas masks) negative pressure: | ☑ YES | ☐ NO |
| c. Cartridges negative air: | ☑ YES | ☐ NO |

11. How often are you expected to use the respirator(s) (check "yes" or "no" for all answers that apply to you)?:

| | | |
|---|---|---|
| a. Escape only (no rescue): | ☐ YES | ☑ NO |
| b. Emergency rescue only: | ☐ YES | ☑ NO |
| c. Less than 5 hours *per week:* | ☐ YES | ☑ NO |
| d. Less than 2 hours *per day:* | ☐ YES | ☑ NO |
| e. 2 to 4 hours per day: | ☐ YES | ☑ NO |
| f. Over 4 hours per day: | ☑ YES | ☐ NO |

12. Describe your work effort (<u>only for the time period you are using the respirator(s)</u>):

| | |
|---|---|
| a) ***Light*** (less than 200 kcal per hour)- indicate the estimated number of hours per shift:<br>Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines. | 4-8 hours |
| b. ***Moderate*** (200 to 350 kcal per hour): indicate the estimated number of hours per shift:<br>Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or *pushing* a wheelbarrow with a heavy load (about 100 lbs.) on a level surface. | 0-0.5 |
| c. ***Heavy*** (above 350 kcal per hour): indicate the estimated number of hours per shift:<br>Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; *shoveling; standing* while bricklaying or chipping castings; *walking*up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.). | n/a |

13.

| | | |
|---|---|---|
| Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: | ☑ YES | ☐ NO |

**RESPIRATOR MEDICAL EVALUATION FORM**

| | |
|---|---|
| If "yes," describe this protective clothing and/or equipment: | rubber boots, glasses, hearing protect |

14.

| | | |
|---|---|---|
| Will you be working under hot conditions (temperature exceeding 77 deg. F): | ☑ YES | ☐ NO |

15.

| | | |
|---|---|---|
| Will you be working under humid conditions: | ☑ YES | ☐ NO |

16. Describe the work you'll be doing while you're using your respirator(s):

grinding polishing and finishing various types of granite, silestone or quartz countertop surfaces

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

none

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

| Toxic Substance | TWA Exposure level (mg/m³ or ppm) | Duration of Exposure (hrs/shift) | Comments, Peaks, etc... |
|---|---|---|---|
| Silica dust | 120 ug/m3 | 4-8 | worst case scenario |
| | | | |
| | | | |
| | | | |

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

material handling using overhead hoists, forklifts.

**RESPIRATOR MEDICAL EVALUATION FORM**

Your Appointment for this respirator medical evaluation is scheduled as listed below. Note that the appointment is during work hours as you will be paid for the time you are at the appointment as if performing normal work. If you can't attend this appointment for some reason it is your responsibility to reschedule this to an acceptable time/day.

| | |
|---|---|
| DATE | |
| TIME | |
| LOCATION | 945 Worcester Street, Natick MA |
| PHONE | (508) 650-6208 |