

Barcode:



150 White Plains Road
Suite 204
Tarrytown, NY 10591



(914) 593-0300 Pt
(914) 347-4901 Fa
www.claritytestin

OCCUPATIONAL HEALTH CONSENT FORM

I hereby grant consent to Clarity Testing Services, Inc and its authorized personnel to perform:

Select Appropriate Tests / Bloodwork:

Respiratory Clearance	()	Respiratory Fit	()
OSHA Lead Level Profile	()	X-Ray	()
Chem panel/CBC	()	UA	()
HEP C	()	EKG	()
Mercury	()	Other _____	()
Other _____	()	Other _____	()

and report all results to my employer or to an authorized Employer and/or Union representative. I understand that only results will be disclosed with no personal and/or medical history included. No other disclosure of the results will be made without my written authorization, with the exception of an authorized representative of the New York State Dept. of Labor and/or the Occupational Health and Safety Administration. This testing does not imply any training whatsoever in Hearing Conservation or the use of hearing protection.

I have read and understand the above consent.

Employee Name: _____ SS # _____ - _____ - _____

Name of Employer: _____ Job Position: _____

Can you read? Yes No Today's Date: _____ Age (to nearest year): _____

Sex: Male Female Height: _____ ft. _____ in. Weight: _____ lbs.

Phone #: (_____) _____ - _____

Employee Home Address (for results notifications only):

Street: _____ City: _____ State: _____ Zip Code: _____

EMPLOYEE SIGNATURE: _____



OSHA MEDICAL QUESTIONNAIRE (To Be Completed By Employee)

Employee Name: _____ SS # _____ - _____ - _____

(The following information must be provided by every employee who has been selected to use any type of respirator, 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.)

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

Have you ever worn a respirator? Yes No If "Yes", what type(s): _____

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/full-face type, powered - air purifying, supplied - air, self-contained breathing apparatus).

(Questions 1 through 15 must be answered by every employee who has been selected to use any type of respirator)

<p>1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever had any of the following conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Seizures (fits) <input type="checkbox"/> Yes <input type="checkbox"/> No b. Diabetes (sugar disease) <input type="checkbox"/> Yes <input type="checkbox"/> No c. Allergic reactions that interfere with your breathing <input type="checkbox"/> Yes <input type="checkbox"/> No d. Claustrophobia (fear of closed-in places) <input type="checkbox"/> Yes <input type="checkbox"/> No e. Trouble smelling odors</p> <p>3. Have you ever had any of the following pulmonary or lung problems? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Asbestosis <input type="checkbox"/> Yes <input type="checkbox"/> No b. Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No c. Chronic bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No d. Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No e. Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No f. Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No g. Silicosis <input type="checkbox"/> Yes <input type="checkbox"/> No h. Pneumothorax (collapsed lung) <input type="checkbox"/> Yes <input type="checkbox"/> No i. Lung Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No j. Broken ribs <input type="checkbox"/> Yes <input type="checkbox"/> No k. Any chest injuries or surgeries <input type="checkbox"/> Yes <input type="checkbox"/> No l. Any other lung problem that you've been told about.</p>	<p>4. Do you currently have any of the following symptoms of pulmonary or lung disease? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No b. Shortness of breath when walking on level ground or walking up a slight hill or incline <input type="checkbox"/> Yes <input type="checkbox"/> No c. Shortness of breath when walking with other people at an ordinary pace on level ground <input type="checkbox"/> Yes <input type="checkbox"/> No d. Have to stop for breath when walking at your own pace on level ground <input type="checkbox"/> Yes <input type="checkbox"/> No e. Shortness of breath when washing or dressing yourself <input type="checkbox"/> Yes <input type="checkbox"/> No f. Shortness of breath that interferes with your job <input type="checkbox"/> Yes <input type="checkbox"/> No g. Coughing that produces phlegm (thick sputum) <input type="checkbox"/> Yes <input type="checkbox"/> No h. Coughing that wakes you early in the morning <input type="checkbox"/> Yes <input type="checkbox"/> No i. Coughing that occurs mostly when you are lying down <input type="checkbox"/> Yes <input type="checkbox"/> No j. Coughing up blood in the last month <input type="checkbox"/> Yes <input type="checkbox"/> No k. Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No l. Wheezing that interferes with your job <input type="checkbox"/> Yes <input type="checkbox"/> No m. Chest pain when you breathe deeply <input type="checkbox"/> Yes <input type="checkbox"/> No n. Any other symptoms that you think may be related to lung problems</p>	<p>5. Have you ever had any of the following cardiovascular or heart problems? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No b. Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No c. Angina <input type="checkbox"/> Yes <input type="checkbox"/> No d. Heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No e. Swelling in your legs or feet (not caused by walking) <input type="checkbox"/> Yes <input type="checkbox"/> No f. Heart arrhythmia <input type="checkbox"/> Yes <input type="checkbox"/> No g. High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No h. Any other heart problem that you've been told about</p> <p>6. Have you ever had any of the following cardiovascular or heart symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Frequent pain or tightness in your chest <input type="checkbox"/> Yes <input type="checkbox"/> No b. Pain or tightness in your chest during physical <input type="checkbox"/> Yes <input type="checkbox"/> No c. Pain or tightness in your chest that interferes with your job <input type="checkbox"/> Yes <input type="checkbox"/> No d. In the past two years, have you noticed your heart skipping or missing a beat? <input type="checkbox"/> Yes <input type="checkbox"/> No e. Heartburn or indigestion that is not related to eating <input type="checkbox"/> Yes <input type="checkbox"/> No f. Any other symptoms that you think might be related to heart or circulation problems</p> <p>7. Do you currently take medication for any of the following problems? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Breathing or lung problems <input type="checkbox"/> Yes <input type="checkbox"/> No b. Heart trouble <input type="checkbox"/> Yes <input type="checkbox"/> No c. Blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No d. Seizures (fits)</p>
---	--	---



OSHA MEDICAL QUESTIONNAIRE Pg 2 (To Be Completed By Employee)

Employee Name: _____ SS # _____ - _____ - _____

<p>8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space _____ and go to question 9)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No a. Eye irritation</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No b. Skin allergies or rashes</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No c. Anxiety</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No d. General weakness or fatigue</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No e. Any other problems that interferes with your use of a respirator</p> <p>9. Would you like to talk to the health care professional that will review this questionnaire about your answers to this questionnaire?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Have you ever lost vision in either eye (temporarily or permanently)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>11. Do you currently have any of the following vision problems?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No a. Wear contact lenses</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No b. Wear glasses</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No c. Color blind</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No d. Any other eye or vision problems</p> <p>12. Have you ever had an injury to your ears, including a broken eardrum?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Do you currently have any of the following hearing problems?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No a. Difficulty hearing</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No b. Wear a hearing aide</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No c. Any other hearing or ear problems</p> <p>14. Have you ever had a back injury?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>15. Do you currently have any of the following musculoskeletal problems?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No a. Weakness in any of you arms, hands, legs, or feet</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No b. Back pain</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No c. Difficulty fully moving your arms and legs</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No d. Pain or stiffness when you lean forward or backward at the waist</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No e. Difficulty fully moving your head up or down</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No f. Difficulty fully moving your head side to side</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No g. Difficulty bending at your knees</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No h. Difficulty squatting to the ground</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No j. Any other muscle or skeletal problem that interferes with using a respirator.</p>
--	---	---

Physician Review _____ MedTech Clarification / Review: _____

EMPLOYEE RESPIRATOR USE DETAIL			
To be completed by Employee. If not complete, employer representative should contact Clarity and provide information.			
Type (s) of respirator (s) to be worn:	Duration (Hours per day)	Frequency (Times per day)	Weight
<input type="checkbox"/> N95	_____	_____	_____
<input type="checkbox"/> Half Face Negative Pressure Cartridge Respirator	_____	_____	_____
<input type="checkbox"/> Full Face Negative Pressure Cartridge Respirator	_____	_____	_____
<input type="checkbox"/> Powered Air Purifying Personal Respirator (PAPR)	_____	_____	_____
<input type="checkbox"/> Air Line (supplied air) Respirator	_____	_____	_____
Special considerations:			
<input type="checkbox"/> Extreme temperatures & humidity			
<input type="checkbox"/> Fully encapsulating suits			
<input type="checkbox"/> Confined spaces			
<input type="checkbox"/> <u>Ambient temperature may reach 120 F ° in hot weather. Fully encapsulating suit with airline may be required. These conditions must be tolerated for 1 hour.</u>			
<input type="checkbox"/> Expected physical effort: <input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> heavy			
<input type="checkbox"/> Comments: _____			



RESPIRATOR FIT TEST

Employee Name: _____ SS # _____ - _____ - _____
 Name of Employer: _____ Today's Date: _____

I. FITTING

Qualitative: Bitrex	Half Face	Full Face
1. Qualitative Fit Check Procedures		
a. Negative pressure check: Pass/Fail	_____	_____
b. Positive pressure check: Pass/Fail	_____	_____
2. Qualitative Fit Test:		
a. Normal breathing	_____	_____
b. Deep breathing	_____	_____
c. Turn head from side-to-side	_____	_____
d. Nod head up and down	_____	_____
e. Rainbow Passage	_____	_____
f. Bend over and touch toes	_____	_____
g. Breathe normally	_____	_____
Minimum Fit Factor	100	1000

3. Overall Evaluation: Pass / Fail

4. Respirator approvals	Manufacturer	Type	Size	Fit Factor
Half face	_____	_____	_____	_____
Full-face	_____	_____	_____	_____

5. Activities requiring respirator _____

6. Issue card Yes/No Date _____

7. Date of medical examination _____

8. Approved with or without corrective lenses (circle one)

9. Training date (date of annual OSHA training) _____

II. SIZE CHECK: Performed for positive pressure respirator using a negative pressure face piece.
 Negative pressure face piece must be same manufacturer as positive pressure face.

1. Quantitative: Portacount 2. Exercises (a-h above) Performed: Yes No

Pass / Fail _____ **Manufacturer** _____ **Size** _____

To be completed by Fit Test Technician: **Employee Signature:** _____
Technician Name _____ **Technician Signature** _____ **Date:** ___ / ___ / ___