150 White Plains Road
Suite 204
Tarrytown, NY 10591

(914) 593-0300 Ph.
(914) 347-4901 Fax
www.claritytesting.com

Barcode:

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**	**( )**
HEP B	**( )**	**Other _____**	**( )**
Mercury	**( )**	**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.

Name: **(please write clearly)** _____ _____
First Name **Last Name**

Last 4 Digits of SS#: _____ Name of Company: _____

Job Position: _____ Name of Supervisor: _____

Are you a Union Member? ❑ Yes ❑ No **If Yes**, Which Union(s): _____ DOB: ____/____/_____
mm dd yyyy

Today's Date: ____/____/_____ Sex: ❑ M ❑ F Height: ____ ft. ____ in. Weight:_____ lbs.
mm dd yyyy

Phone #: (_____) _____ - _____ Email: _____

Address: _____ Apt: _____

City _____ State: _____ ZIP Code: _____

SIGNATURE: _____

Rev.03/28/2022

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CONSENT FOR EXAMINATION

1. I authorize Clarity Testing and its practitioners to evaluate my fitness for duty as required by my employer, my union, or other approved third party (the "Contracting Party"). I understand that such evaluation does not establish a patient-practitioner relationship between me and Clarity Testing or any of its practitioners, nor will Clarity Testing provide any future treatment or services to me, unless I require another fitness for duty examination.

2. I understand that the sole purpose of this examination is to evaluate my fitness for duty, as required by the Contracting Party.

3. By my signature below I am authorizing a report regarding Clarity Testing's findings to be sent to the Contracting Party.

4. I understand that if I have concerns about my physical health or well-being, I should request copies of my examination results and contact my regular physician.

5. I understand that Clarity Testing will have no liability for the results of my examination or in regard to any information that is obtained during the examination, regardless of whether or not such information is provided to me. I irrevocably release, waive and forever discharge any and all claims and causes of action of whatever kind or character that I may have had, may now have, or would later be able to assert (at law, in equity or otherwise) against Clarity Testing for its findings during my fitness for duty examination, including but not limited to, disclosing the findings to the Contracting Party and not disclosing the findings to me.

I acknowledge that I have read and fully understand this consent and release form. Any questions I may have had regarding this form were sufficiently answered.

Print Name: _____

Signature: _____ Date: _____

Clarity Testing Representative: _____

Remarks: _____

_____

Signature: _____ Date: _____

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OSHA MEDICAL QUESTIONAIRE (To Be Completed By Employee)

Employee Name: _____ SS # XXX - XX - ___ ___ ___ ___

(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 16 must be answered by every employee who has been selected to use any type of respirator)

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?
❑ **Yes** ❑ **No** a. Seizures (fits)
❑ **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

3. Have you ever had any of the following pulmonary or lung problems?
❑ **Yes** ❑ **No** 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.

4. If you have Asthma:
❑ **Yes** ❑ **No** a. Are you on medication?
If yes, how often do you take it? _____
b. How frequent are your attacks? _____
_____
❑ **Yes** ❑ **No** c. Have you ever been hospitalized or needed the ER for Asthma?

5. Do you currently have any of the following symptoms of pulmonary or lung disease?
❑ **Yes** ❑ **No** a. Shortness of breath
❑ **Yes** ❑ **No** b. Shortness of breath when walking 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

6. Have you ever had any of the following cardiovascular or heart problems?
❑ **Yes** ❑ **No** 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
❑ **Yes** ❑ **No** g. High blood pressure
❑ **Yes** ❑ **No** h. Any other heart problem that you've been told about

7. Have you ever had any of the following cardiovascular or heart symptoms?
❑ **Yes** ❑ **No** a. Frequent pain or tightness in your chest
❑ **Yes** ❑ **No** b. Pain or tightness in your chest during physical
❑ **Yes** ❑ **No** c. Pain or tightness in your chest that interferes with your job
❑ **Yes** ❑ **No** d. In the past two 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** f. Any other symptoms that you think might be related to heart or circulation problems

8. Do you currently take medication for any of the following problems?
❑ **Yes** ❑ **No** a. Breathing or lung problems
❑ **Yes** ❑ **No** b. Heart trouble
❑ **Yes** ❑ **No** c. Blood pressure
❑ **Yes** ❑ **No** d. Seizures (fits)

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Employee Name: _____ SS # XXX - XX - ___ ___ ___ ___

9. 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 10)

❑ **Yes** ❑ **No** 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 problems that interfere with your use of a respirator

10. Would you like to talk to the health care professional that will review this questionnaire about your answers to this questionnaire?
❑ **Yes** ❑ **No**

11. Have you ever lost vision in either eye (temporarily or permanently)?
❑ **Yes** ❑ **No**

12. Do you currently have any of the following vision problems?
❑ **Yes** ❑ **No** a. Wear contact lenses
❑ **Yes** ❑ **No** b. Wear glasses
❑ **Yes** ❑ **No** c. Color blind
❑ **Yes** ❑ **No** d. Any other eye or vision problems

13. Have you ever had an injury to your ears, including a broken eardrum?
❑ **Yes** ❑ **No**

14. Do you currently have any of the following hearing problems?
❑ **Yes** ❑ **No** a. Difficulty hearing
❑ **Yes** ❑ **No** b. Wear a hearing aide
❑ **Yes** ❑ **No** c. Any other hearing or ear problems

15. Have you ever had a back injury?
❑ **Yes** ❑ **No**

16. Do you currently have any of the following musculoskeletal problems?
❑ **Yes** ❑ **No** a. Weakness in any of your arms, hands, legs, or feet
❑ **Yes** ❑ **No** b. Back pain
❑ **Yes** ❑ **No** c. Difficulty fully moving your arms and legs
❑ **Yes** ❑ **No** d. Pain or stiffness when you lean forward or 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 that interferes with using a respirator.

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
❒ N95	_____	_____	_____
❒ Half Face Negative Pressure Cartridge Respirator	_____	_____	_____
❒ Full Face Negative Pressure Cartridge Respirator	_____	_____	_____
❒ Powered Air Purifying Personal Respirator (PAPR)	_____	_____	_____
❒ Air Line (supplied air) Respirator	_____	_____	_____

Special considerations:
❒ Extreme temperatures & humidity
❒ Fully encapsulating suits
❒ Confined spaces
❒ 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.
❒ Expected physical effort: ❒ light ❒moderate ❒ heavy
❒ Comments: _____

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Employee Name: _____ SS # XXX - XX - ___ ___ ___ ___

Name of Employer: _____ Today's Date: _____

MedTech Data (To be Completed by Med-Tech)

Height: _____ Weight_____

Blood Pressure: ____ / _____

Heart: ___ Rate __ Regular __ Irregular

Respiratory: ___ Rate __ Clear __ Wheezing

Other:_____
_____

Med Tech Initials: _____

Physician Medical Certification (To be Completed by Physician)

___ **OSHA Respiratory Questionnaire Reviewed**

___ **Pulmonary Function Test Reviewed**

___ **Vital Signs Evaluation Reviewed**

Based upon the above clinical data, this employee is found to be:

___ **Qualified to wear a Respirator under *CFR Part 1910.134***

___ **In need of further medical information / follow up:**_____
_____
_____

___ **Not qualified to wear a Respirator**_____

Physician Signature: _____ ***DATE:*** _____ / ____ / ____

Jeffrey Altholz, M.D.
NYS LIC #170767
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Tarrytown, NY 10591

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RESPIRATOR FIT TEST

Employee Name: _____ SS # XXX -XX - ___ ___ ___ ___

Name of Employer: _____ Today's Date: _____

I. SENSITIVITY TEST: **Pass____** **Fail____**

II. 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)_____

III. <u>SIZE CHECK</u>: Preformed 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**_____

<u>To be completed by Fit Test Technician:</u> **Employee Signature:** _____

_____ _____ Date: ___ / ___ / ___

Technician Name **Technician** Signature