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.

Employee Name: _____ SS # XXX - XX - ___ ___ ___ ___
Please print your name clearly

Name of Company: _____ Job Position: _____

Are you a Union Member? ❑ Yes ❑ No Which Union: _____ Today's Date: _____

Sex: ❑ M ❑ F Height: _____ft. _____in. Weight: _____lbs.

Cell Phone #: (_ _ _) __ __ _ - __ __ __ __ Birthdate:___/___/____ Age (to nearest year):_____

Address:_____
City _____ State: ____ ZIP Code:_____

EMPLOYEE SIGNATURE: _____

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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 15 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. 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

5. 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

6. 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

7. 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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OSHA MEDICAL QUESTIONAIRE Pg 2 (To Be Completed By Employee)

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

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)
❑ **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 interferes with your use of a respirator

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

I0. Have you ever lost vision in either eye (temporarily or permanently)?
❑ **Yes** ❑ **No**

11. 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

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

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

15. Do you currently have any of the following musculoskeletal problems?
❑ **Yes** ❑ **No** a. Weakness in any of you 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 I 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

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.
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RESPIRATOR FIT TEST

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

Name of Employer: _____ Today's Date: _____

I. SENSITIVIY 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.Activites 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) Preformed: Yes No

Pass / Fail_____ Manufacturer_____ Size_____

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

_____ _____ Date: ___ / ___ / ___

Technician Name **Technician** Signature