



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: _____



OSHA MEDICAL QUESTIONNAIRE (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)

<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>
---	--	---



Employee Name: _____

SS # XXX - XX - _____

<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 interfere 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 your 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: _____			



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
Westchester Medical Care, PLLC
150 White Plains Rd
Tarrytown, NY 10591



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

	Manufacturer	Type	Size	Fit Factor
4. Respirator approvals				
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. 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: ___ / ___ / ___