NDSU NORTH DAKOTA STATE UNIVERSITY

To: Potential Respirator Wearing Individuals

Fm: Brandon Gustafson, Associate Director, EHS

Date: May 1, 2023

Ref: Instructions for completing and filing respirator evaluation form

NDSU Policy requires that all employees required to wear a respirator receive medical clearance from a Physician or other Licensed Health Care Professional (PLHCP). This process contains three forms; Employer Authorization and Information for Respiratory Evaluation, PLHCP Written Statement for Respirators (Employee), and the OSHA Respirator Medical Evaluation Questionnaire. These forms are required to be completed and submitted to one of the two NDSU Occupational Healthcare Providers (Providers) as identified below. They will perform the medical evaluation associated with the respirator clearance. The steps involved in filling out and sending the information are as follows:

1. The first page titled "Employer Authorization and Information for Respiratory Evaluation" is to be completed by the employee's supervisor and Medical Provider. The supervisor is to complete only the top portion as indicated.

2. The supervisor must pass the forms on to the employee so that they can complete the remaining (non-Provider) items.

3. The second page titled "PLHCP Written Statement for Respirators (Employee)" contains basic employee information along with an approval area for the Provider's use. The employee is to fill out only the highlighted areas at the top of this page.

4. The employee will then fill out the questionnaire for the corresponding NDSU Occupational Healthcare Provider they wish to see and return to provider a minimum of one day before scheduled fit test along with authorization for corresponding NDSU Occupational Healthcare Provider, employer authorization, and PLHCP written statement for respirators.

5. Please note: After choosing your Provider, fill out their Authorization for Treatment Form (**Authorization – Sanford** or **Authorization – Essentia**) All forms can be found on the NDSU forms page https://www.ndsu.edu/forms/#purchasing12 under UPSO-Safety-Respirator. *Note that the questionnaire is confidential medical information and is not intended for the employer to read.*

6. Upon reviewing the forms, the Provider will issue clearance with an expiration date, deny clearance, indicate special conditions and/or determine that additional medical evaluation (exam) is required. This notice will be issued to both NDSU and the employee through the use of the first two pages of the form.

Essentia Health North Fargo Clinic 1100 19th Ave N Fargo, ND 58102	Sanford Health 3838 12th Ave. N. Fargo, ND 58102

If you have any questions while filling out the information, please call the University Police and Safety Office at 231-7759.

EMPLOYER AUTHORIZATION AND INFORMATION FOR RESPIRATORY EVALUATION

EMPLOYER TO COMPLETE THE FOLLOWING

NDSU—Department _____
Dept # _____, PO Box 6050
Fargo, ND 58108-6050

Employee Name:_____

Employer: North Dakota State University

Cc: NDSU UP&SO
Dept #3300, PO Box 6050
Fargo, ND 58108-6050

Check type of respirator(s) to be used (Check √ all that apply)

☐Air-purifying (non-powered) ☐Air-purifying (powered)
☐Atmosphere supplying Respirator
☐Combination air-line SCBA
☐Continuos-Flow Respirator
☐Supplied-Air Respirator
☐Open Circuit SCBA ☐Closed Circuit SCBA
☐Dust Mask ☐1/2 Face with Canisters ☐Full Face with Canisters
Make:_____ Model:_____ Cartridge:_____

Special Work Conditions
(Check √ all that apply)

☐High Places ☐Enclosed Places ☐Protective Clothing
☐Temperature Extremes ☐Mostly Cold ☐Mostly Hot
☐Other:_____
Questionnaire will be: ☐Hand Carried ☐Mailed ☐Other

Extent of Usage (Check √ all that apply)

☐On a daily basis_____ Total Hours
☐Occasionally-but not more than twice a week____Total Hours
☐Rarely-or for Emergency situations only_____Total Hours

Expected Physical Effort Required (Check √ all that apply)

☐Light ☐Moderate ☐Heavy

Exposure to Hazardous Material (Check √ all that apply)

☐Arsenic ☐Benzene
☐Coke Oven ☐Cotton Seed/Dust
☐Cadmium ☐Formaldehyde
☐Methylene Chloride ☐Lead
☐Textiles ☐Chromium
☐Others:_____

Evaluation Authorized By:_____
Signature of Employer Representative

DO NOT WRITE BELOW THIS LINE DO NOT WRITE BELOW THIS LINE DO NOT WRITE BELOW THIS LINE

PLHCP[1] WRITTEN STATEMENT FOR RESPIRATORS (EMPLOYER)

PHYSICIAN WILL COMPLETE THE FOLLOWING

This report may contain confidential medical information and is intended for the designated employer contact only. The Americans with Disabilities Act (ADA) imposes very strict limitations on the use of information obtained during physical examinations of qualified individuals with disabilities. All information must be collected and maintained on separate forms, in separate files, and must be treated as a confidential medical record, with the following exceptions.

- Supervisors and managers may be informed about necessary restrictions on the work or duties of an employee and necessary accommodations.
- First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment.

Based upon my findings, I have determined that this individual (Check √ all that apply)

☐Employee must schedule a medical examination with _____ prior to respirator approval and usage.
☐Class I – No Restrictions on Respirator Use
☐Class II – Some Specific Use For Respirators ☐To be used for Emergency response or Escape Only ☐Other:_____
☐Class III – Respirator Use is NOT PERMITTED
☐Further Testing/Evaluation is Required[2]
☐Fit Test Required ☐Fit Test Performed satisfactorily
☐Fit Test Performed Unsatisfactorily ☐Fit Test NOT performed at:_____
☐Special prescription eyewear needed to accommodate respirator ☐Special prescription eyewear needed to accommodate respirator
☐Facial hair needs to be shaved to assure tight seal on certain facemasks

(Check √ ALL that apply)

☐The above individual HAS been examined for respirator fitness in accordance with 29 CFR 1910.134. This limited evaluation is specific to respirator use only. Employees should be instructed to report any difficulties in using respirators or change of any physical status to their supervisor or physician. This evaluation included the Respiratory Questionnaire outlined in 29 CFR 1910.134.

☐The above individual HAS NOT been examined by me for respirator fitness. The employee's medical evaluation consisted of a review of OSHA's Medical Evaluation Questionnaire in Appendix C Part A Section 2. In accordance with 29 CFR 1910.134, this limited evaluation is specific to respirator use only. Employees would be instructed to report any difficulties in using respirators or change of any physical status to their supervisor or physician. This evaluation included the Respiratory Questionnaire outline in 29 CFR 1910.134.

☐In accordance with specific OSHA requirements, I have informed the above named individual of the results of this evaluation and of any medical condition resulting from exposures that may require further explanation or treatment. Where applicable, the above named individual has been informed of the increased risk of lung cancer attributable to the combined effect of smoking and asbestos, lead and/or other chemical exposure(s).

_____ _____
Physicians' Signature **Physician's Name (Printed)**

_____ _____ _____
Physician's License Number (Optional in Most States) **Date of Exam** **Expires On**

[1] Physician or other Licensed Healthcare Professional
[2] Employee must seek further medical evaluation by a private physician who must submit a report to_____of his/her findings

To be maintained in the medical provider's file with a copy to NDSU UP&SO

PLHCP[1] WRITTEN STATEMENT for RESPIRATORS (EMPLOYEE)

Service Date:_____

Employee Name:_____ **Empl/Student ID:**_____

_____

Address:

_____

_____

_____

Employer: North Dakota State University – Dept: _____, Dept #_____, PO Box 6050, Fargo, ND 58108-6050

You were evaluated in this office of your medical status related to your physical capability to wear a respirator. (Check √ one that applies)

☐There were no abnormal findings that would hamper your ability to perform your job duties while wearing a respirator.
☐The abnormal findings listed below were not related to wearing a respirator but should be reported to your personal physician for further evaluation.

_____

_____

Based upon the results of this evaluation it is my opinion that you: (Check √ ALL that apply)

☐Are qualified to wear a respirator.
☐Have the following restrictions concerning respirator usage.
☐ARE NOT qualified to wear a respirator.
☐Require further testing by your private physician who must submit a written report of his/her findings to _____ so that a final decision on your ability to wear a respirator can be made.
☐Must wear Special prescription eyewear needed to accommodate respirator.
☐Must use an Eye glass conversion kit.
☐May need to shave Facial hair to assure tight seal on certain facemasks.
☐Need to stop smoking.

(Check √ ALL that apply)

☐The above individual HAS been examined for respirator fitness in accordance with 29 CFR 1910.134. This limited evaluation is specific to respirator use only. Employees should be instructed to report any difficulties in using respirators or change of any physical status to their supervisor or physician. This evaluation included the Respiratory Questionnaire outlined in 29 CFR 1910.134.
☐The above individual HAS NOT been examined by me for respirator fitness. The employee's medical evaluation consisted of a review of OSHA's Medical Evaluation Questionnaire in Appendix C Part A Section 2. In accordance with 29 CFR 1910.134, this limited evaluation is specific to respirator use only. Employees would be instructed to report any difficulties in using respirators or change of any physical status to their supervisor or physician. This evaluation included the Respiratory Questionnaire outline in 29 CFR 1910.134.
☐In accordance with specific OSHA requirements, I have informed the above named individual of the results of this evaluation and of any medical condition resulting from exposures that may require further explanation or treatment. Where applicable, the above named individual has been informed of the increased risk of lung cancer attributable to the combined effect of smoking and asbestos, lead and/or other chemical exposure(s).

Respirators must be properly selected based on the containment and concentration levels to which the worker will be exposed. Failure to follow the use and fitting instructions and warnings for proper use contained on the respirator packaging and/or failure to wear the respirator during all times of exposure can reduce the respirator's effectiveness and result in sickness or death. Wearer must be trained in the proper care of any respirator. Refer to product literature and packaging for specific information regarding fit

_____ _____
PLHCP Signature Employee's Signature

_____ _____
PLHCP Name (Optional) Expiration Date

[1] Physician or other Licensed Healthcare Professional

To be maintained in the medical provider's file with a copy to NDSU UP&SO