NDSU NORTH DAKOTA STATE UNIVERSITY

To: Potential Respirator Wearing Individuals

Fm: Bret Mayo, Associate Director, EHS

Date: April 15, 2020

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 third page begins the questionnaire titled "OSHA Respirator Medical Evaluation Questionnaire." The employee should fill out all of the information requested on the first three and a half pages of the questionnaire (the page numbers on the bottom of this section are 1-4 of 7). Complete all information up to the point on page 4 of 7 marked "To the PLHCP".

5. The last three pages of that section should NOT be filled out at this time. They may eventually be used during the Provider's evaluation of the information.

6. Once completed, choose which Occupational Healthcare Provider you will use. After choosing your Provider, fill out their Authorization for Treatment Form (**Authorization – Sanford** or **Authorization – Essentia** on the website) and deliver this along with the three forms to the chosen Provider at the address indicated below. *Note that the larger seven page questionnaire is confidential medical information and is not intended for the employer to read.*

7. 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 West Fargo Clinic 1401 13th Ave. E. West Fargo, ND 58078	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.

UNIVERSITY POLICE AND SAFETY OFFICE
University Police and Safety | NDSU Dept 3300 | PO Box 6050 | Fargo ND 58108-6050
701.231.7759 | Fax 701.231.6739 | www.ndsu.edu

NDSU is an EO/AA university

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

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Date:_____ **Chart #:**_____
Age:_____ **Sex:**_____ Empl/StudentID _____
Name:_____ **Job Title:**_____
Employer Name:_____

TO THE EMPLOYER
Answers to questions in Section 1, and to question 9 in section 2 of Part A, do not require medical examination. However, it does require that a Physician or Licensed Health Care Professional (PLHCP) review this questionnaire and answer any questions you may have concerning the questions asked in this questionnaire.

TO THE EMPLOYEE
Can you read? (Check √ One) ☐Yes ☐No
Your employer must allow you to answer this questionnaire during normal working, 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, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

TO THE PHYSICIAN OR OTHER LICENSED HEALTH CARE PROFESSIONAL (PLHCP)

Review Part A Sections 1 and 2. When an employee answers YES to any of the questions in Section 2 and the questionnaire is not administered in conjunction with a physical examination, the employee needs to be considered for a follow-up physical examination with particular emphasis on those areas in which the employee answered YES. When an employee answers YES to any of the questions in Section 2 and this questionnaire is completed in conjunction with a physical examination, the physician will place particular emphasis upon those areas to which the employee answered YES. In either situation the PLHCP will complete the "PLHCP Written Statement" to both the employee and employer within 2 days.

PART A SECTION 1 (MANDATORY)
The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Your height:_____ft. _____in.
2. Your weight: _____ lbs.
3. Your job title:_____
4. A phone number where you can be reached by the health care professional who will review this questionnaire (Include area code):_____
5. The best time to phone you at this number is: _____ am/_____ pm.
6. Has your employer told you how to contact the health care professional who will review this questionnaire? (Check √ One) ☐Yes ☐No
7. Check the type of respirator you will use (you can check more than one category):
   a._____ N, R, or P disposable respirator (filter-mask, non cartridge type only)
   b._____ Other type (for example, half- or full-facepiece type, powered – air purifying, supplied – air, self-contained breathing apparatus).
8. Have you worn a respirator (Check √ One) ☐Yes ☐No
   If "Yes", what type(s):_____

To be filed in the Medical Provider's employee medical file

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

PART A SECTION 2 (MANDATORY)
Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. (please check "Yes" or "No"

1. ☐Yes ☐No **Do you currently smoke tobacco, or have you smoked tobacco in the last month?**

2. **Have you ever had any of the following conditions?**
   - ☐Yes ☐No a. Seizures (fits)
   - ☐Yes ☐No b. Diabetes (sugar diabetes)
   - ☐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 your 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

To be filed in the Medical Provider's employee medical file

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 activity
☐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)

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

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these question is voluntary.

10. ☐Yes ☐No **Have you ever lost vision in either eye (temporarily or permanently)**

11. **Do you currently have any of the following vision problems?**

☐Yes	☐No	Wear contact lenses
☐Yes	☐No	Wear glasses
☐Yes	☐No	Color blind
☐Yes	☐No	Any other eye or vision problems

To be filed in the Medical Provider's employee medical file

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

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

15. **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

TO THE PLHCP

Check √ the <u>ONE</u> that applies

☐ I have reviewed Part A Section 2 of this questionnaire <u>with</u> the employee and <u>I do not recommend</u> that a physical examination be performed at this time.

☐ I have reviewed Part A Section 2 of this questionnaire <u>with</u> the employee and <u>I am recommending</u> that a physical examination be performed at this time.

☐ I have reviewed Part A Section 2 of this questionnaire <u>without</u> the employee and <u>I do not recommend</u> that a physical examination be performed at this time.

☐ I have reviewed Part A Section 2 of this questionnaire <u>without</u> the employee and <u>I am recommending</u> that a physical examination be performed at that time.

_____ _____

PLHCP Signature Employee Signature (When Available)

_____

Date

To be filed in the Medical Provider's employee medical file

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

PART B of this OSHA Questionnaire is discretionary. The health care professional who will be reviewing this questionnaire will determine if this part needs to be completed by the employee.

Part B (DISCRETIONARY)

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. ☐Yes ☐No **In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amount of oxygen?**
   ☐Yes ☐No If "Yes", do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working under these conditions?
2. ☐Yes ☐No **At work or at home. Have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g. gases, fumes, or solvents, hazardous airborne chemicals)?**
   If "Yes", name the chemicals if you know them:_____
   _____

3. **Have you ever worked with any of the materials, or under any of the conditions, listed below:**
   ☐Yes ☐No Asbestos
   ☐Yes ☐No Silica
   ☐Yes ☐No Tungsten/Cobalt (e.g. grinding or welding this material)
   ☐Yes ☐No Beryllium
   ☐Yes ☐No Aluminum
   ☐Yes ☐No Coal (for example; mining)
   ☐Yes ☐No Iron
   ☐Yes ☐No Tin
   ☐Yes ☐No Dusty environments
   ☐Yes ☐No Any other hazardous exposures
   If "Yes", describe these exposures:_____
   _____

4. **List any second jobs or side businesses you have:**_____
   _____
5. **List any previous occupations:**_____
   _____
6. **List your current and previous hobbies:**_____
   _____

7. ☐Yes ☐No **Have you been in the military services?**
   If "Yes", were you exposed to biological or chemical agents (either in training or combat)
   ☐Yes ☐No

8. ☐Yes ☐No **Have you ever worked on a HAZMAT team?**

9. ☐Yes ☐No **Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in the questionnaire, are you taking any other medications for any reason (including over the counter medications)**
   If "Yes", name the medications if you know them:_____

To be filed in the Medical Provider's employee medical file

10. **Will you be using any of the following items with your respirator?**

☐Yes ☐No a. HEPA Filters
☐Yes ☐No b. Canisters (for example; gas masks)
☐Yes ☐No c. Cartridges

11. **How often are you expected to use the respirator(s) (check "yes" or "no" for all answers that apply to you)?**

☐Yes ☐No a. Escape only (no rescue)
☐Yes ☐No b. Emergency rescue only
☐Yes ☐No c. Less than 5 hours per week
☐Yes ☐No d. Less than 2 hours per week
☐Yes ☐No e. 2 to 4 hours per day
☐Yes ☐No f. Over 4 hours per day

12. **During the period you are using the respirator(s) , is your work effort:**

☐Yes ☐No a. Light (less than 200kcal per hour)
Examples of light work are sitting while writing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs) or controlling machines.
If "Yes", how long does this period last during the average shift:_____hrs. _____mins.?

☐Yes ☐No b. Moderate (200 to 350 kcal per hour)
Examples of moderate work effort are sitting while nailing or filing; driving truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs) at trunk level; walking on a level surface about 2 mph or down a 5 – degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (100 lbs.) on a level surface.

☐Yes ☐No c. Heavy (above 350 kcal per hour)
If "Yes", how long does this period last during the average shift_____hrs. _____mins.?
Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking on a level surface about 2 mph or down a 5 - degree grade about 3 mph; or walking up an 8- degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.)

13. ☐Yes ☐No **Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator?**
If "Yes", describe this protective clothing and/or equipment._____
_____

14. ☐Yes ☐No **Will you be working under hot conditions (temperature exceeding 77 deg. F.)?**

15. ☐Yes ☐No **Will you be working under humid conditions?**

16 **Describe the work you'll be doing while you're using your respirator(s)**
_____
_____
_____
_____

To be filed in the Medical Provider's employee medical file

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

1. **Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):**_____
_____

2. **Provide the following information, if you now it, for each toxic substance that you'll be exposed to when you're using your respirator.**
Name of first toxic substance:_____
Estimated maximum exposure per shift:_____
Duration of exposure per shift:_____
Name of second toxic substance:_____
Estimated maximum exposure per shift:_____
Duration of exposure per shift:_____
Name of third toxic substance:_____
Estimated maximum exposure per shift:_____
Duration of exposure per shift:_____
Name of any other toxic substances that you'll be exposed to while using your respirator(s):_____
_____
_____

3. **Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example;rescue, security):**_____
_____

Appendix D to Section 1910.134 (Mandatory) Information for Employees Using Respirators When Not Required Under the Standard

Respirators are an effective method of protection against hazards when properly selected and worn. Respirators use is encouraged, even when exposures are below the exposure limit, to provide additional level of comfort and so that the respirator itself does not represent a hazard. However, if the respirator is used improperly or not kept clean, the respirator itself can become a hazard to the worker. Sometimes, workers may wear respirators to avoid exposure to hazards, even if the amount of hazardous substances does not exceed the limits set forth by OSHA standards. If your employer provides respirators for your voluntary use, or if you provide your own respirator, you need to take certain precautions to be sure that the respirator itself does not represent a hazard

You should do the following:
1. Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirators limitations.
2. Choose respirators certified for use to protect against the contaminants of concern. NIOSH, the National Institute for Occupational Safety and Health and the U.S Department of Health and Human Services, certifies respirators. A label or statement of certification should appear on the respirator or respirator packaging. It will tell you what the respirator is designed for and how much it will protect you.
3. Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designed to protect against. For example, a respirator designed to filter dust particles will not protect you against gases, fumes, vapors, or very small solid particles of fumes or smoke.
4. Keep track of your respirator so that you do not mistakenly use someone else's respirator.

To be filed in the Medical Provider's employee medical file