PRODUCER RESPIRATOR USE CERTIFICATION EVENT

Occupational Team Solutions will facilitate the Medical Review and Respirator Fit Test certification to be held at GRANVILLE COUNTY EXTENSION OFFICE at 125 OUTER LOOP ROAD OXFORD, N.C. on JANUARY 21, 2025

# DEADLINE TO RECEIVE MEDICAL. FORMS AND PAYMENT -JANUARY 15, 2025

Step One:

Complete Medical Questionnaire. Mail medical forms and remit payment payable to

Occupational Team Solutions. Cost $ 95.00

NOTE: PLEASE PROVIDE OUR TEAM A PHONE NUMBER INCLUDING AREA CODE TO CONTACT YOU FOR SCHEDULING PURPOSES.

MAILING ADDRESS:

Occupational Team Solutions

P.O. Box 38517

Greensboro, NC 27438

Step Two:

Contact our office team IF YOU HAVE NOT RECEIVED AN APPOINTMENT OFFER within 7 days of sending in your forms and payment. Contact us at (336) 210-5658.

Step Three:

Bring respirator mask and filters to your appointment. Please remove facial hair down to one two-day growth for best opportunity to pass the fit test.

QUESTIONS? PLEASE CONTACT YOUR ACCOUNT REPRESENTATIVE:

LEA A. HOLLINGER (336) 210-5658

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 . Today's date:

1. Your name:
2. Your age (to nearest year):
3. Sex (circle one): Male/Female

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| 5. | Your height: | ft. | in. |
| 6. | Your weight: | lbs. |  |

1. Your job title:
2. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):
3. The best time to phone you at this number:
4. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No
5. Check the type of respirator you will use (you can check more than one category):
	1. N, R, or P disposable respirator (filter-mask, non-cartridge type only).
	2. Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
6. Have you worn a respirator (circle one): Yes/No If "yes," what type(s):

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 circle "yes" or "no").

 YES NO

1 . Do you currently smoke tobacco, or have you smoked tobacco in the last month?

1. Have you ever had any of the following conditions?
	1. Seizures
	2. Diabetes (sugar disease)
	3. Allergic reactions that interfere with your breathing
	4. Claustrophobia (fear of closed-in places)
	5. Trouble smelling odors
2. Have you ever had any of the following pulmonary or lung problems?
	1. Asbestosis
	2. Asthma

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* 1. Chronic bronchitis
	2. Emphysema
	3. Pneumonia
	4. Tuberculosis
	5. Silicosis
	6. Pneumothorax (collapsed lung)

Lung cancer

* 1. Broken ribs
	2. Any chest injuries or surgeries

Any other lung problem that you've been told about

1. Do you currently have any of the following symptoms of pulmonary or lung illness?
	1. Shortness of breath
	2. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
	3. Shortness of breath when walking with other people at an ordinary pace on level ground
	4. Have to stop for breath when walking at your own pace on level ground
	5. Shortness of breath when washing or dressing yourself
	6. Shortness of breath that interferes with your job
	7. Coughing that produces phlegm (thick sputum)
	8. Coughing that wakes you early in the morning

Coughing that occurs mostly when you are lying down

* 1. Coughing up blood in the last month
	2. Wheezing

Wheezing that interferes with your job

* 1. Chest pain when you breathe deeply
	2. Any other symptoms that you think may be related to lung problems
1. Have you ever had any of the following cardiovascular or heart problems?
	1. Heart attack
	2. Stroke
	3. Angina
	4. Heart failure

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* 1. Swelling in your legs or feet (not caused by walking)
	2. Heart arrhythmia (heart beating irregularly)
	3. High blood pressure
	4. Any other heart problem that you've been told about

6. Have you ever had any of the following cardiovascular or heart symptoms?

* 1. Frequent pain or tightness in your chest
	2. Pain or tightness in your chest during physical activity
	3. Pain or tightness in your chest that interferes with your job
	4. In the past two years, have you noticed your heart skipping or missing a beat
	5. Heartburn or indigestion that is not related to eating
	6. Any other symptoms that you think may be related to heart or circulation problems 
1. Do you currently take medication for any of the following problems?
	1. Breathing or lung problems
	2. Heart trouble
	3. Blood pressure
	4. Seizures
2. 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.) 
	1. Eye irritation
	2. Skin allergies or rashes
	3. Anxiety
	4. General weakness or fatigue
	5. Any other problem that interferes with your use of a respirator
3. 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 a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

1. Have you ever lost vision in either eye (temporarily or permanently)?
2. Do you currently have any of the following vision problems?
	1. Wear contact lenses
	2. Wear glasses

c. Color blind

d. Any other eye or vision problem

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1. Have you ever had an injury to your ears, including a broken eardrum?
2. Do you currently have any of the following hearing problems?
	* 1. Difficulty hearing
		2. Wear a hearing aid
		3. Any other hearing or ear problem
3. Have you ever had a back injury?
4. Do you currently have any of the following musculoskeletal problems?
	* 1. Weakness in any of your arms, hands, legs, or feet
		2. Back pain
		3. Difficulty fully moving your arms and legs
		4. Pain and stiffness when you lean forward or backward at the waist
		5. Difficulty fully moving your head up or down
		6. Difficulty fully moving your head side to side
		7. Difficulty bending at your knees
		8. Difficulty squatting to the ground

Climbing a flight of stairs or a ladder carrying more than 25 lbs.

 j. Any other muscle or skeletal problem that interferes with using a respirator

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| This infosheet does not include the questions in Part B because they are not mandatory; rather, they may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.OSHA Educational MaterialsOSHA has an extensive publications program. For a listing of free items, visit OSHA's web site at www.osha.gov/publications or contact the OSHA Publications Office, U.S. Department of | Labor, 200 Constitution Avenue, N.W., N-3101, Washington, DC 20210. Telephone (202) 693-1888 or fax to (202) 693-2498.Contacting OSHATo report an emergency, file a complaint or seek OSHA advice, assistance or products, call(800) 321-OSHA (6742) or contact your nearest OSHA regional, area, or State Plan office; TTY:1-877-889-5627. |

This InfoSheet is not a standard or regulation, and it creates no new legal obligations. Itcontains recommendations as well as descriptions of mandatory Safety and health standards. The recommendations are advisory in nature, informational in content, and are intended to assist employers in providing a safe and healthful workplace. The Occupational Safety and Health Act requires employers to comply with safety and health standards and regulations promulgated by OSHA or by a state with an OSHA-approved state plan. In addition, the Act's General Duty Clause, Section requires employers to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm,

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