

**North Carolina  
Department of Agriculture and Consumer Services  
Medical Protocols**

**Respirator Medical Certification Program**

**A. Purpose**

1. To evaluate the ability of the employee to perform his/her job while utilizing respiratory protective equipment.
2. To insure compliance with the OSHA standard on Respiratory Protection, 29 CFR 1910.134. (Revised in 1998)

**B. Respirator Medical Certification**

Using a respirator may place a physiological burden on employees that varies with the type of respirator worn, the job and workplace conditions in which the respirator is used, and the medical status of the employee. Accordingly, the following procedures shall be used by management to medically certify respirator users:

1. **Initial Medical Exam** - Before any employee is issued a respirator, Part A of “NCDA&CS’ Periodic Health Questionnaire” (Appendix A) must be completed by the employee and shall be sent with the questionnaire and “Employee Respirator Use Profile” form (Appendix B) to a local physician or health care professional for evaluation. The “Employee Respirator Use Profile” form is to be completed by the employee’s supervisor and sent with the employee to the medical examination.
2. **Follow-up Medical Exam** - The local physician shall determine the frequency for follow-up exams on an individual basis. However, the minimum frequency for follow-up exams shall be once every 5 years, regardless of initial medical exam results.

Other factors which may influence the frequency of medical recertification include:

- a) an employee reports signs or symptoms that are related to the ability to use a respirator;
- b) a physician or health care professional, supervisor or department safety director informs site management that the employee needs to be reevaluated;
- c) information from the respiratory protection program, including observations made during fit testing and program evaluation, indicates a need for employee reevaluation; or
- d) a change occurs in workplace conditions (e.g., physical work effort, protective clothing, temperature) that may result in a substantial increase in the physiological burden placed on an employee.

Any requests for medical recertification, other than the 5 year minimum interval or the specified interval stipulated on the Physician’s Opinion Letter, must be approved by the department safety director by submitting “NCDA&CS Respirator Medical Recertification Request” form to the department safety director (Appendix D).

3. **Medical Determination** - In determining the ability to use a respirator, the site manager shall obtain a written recommendation regarding the employee's ability to use the respirator from the physician. The recommendation shall provide the following information:
- a) any limitations on respirator use related to the medical condition of the employee, or relating to the workplace conditions in which the respirator will be used, including whether or not the employee is medically able to use the respirator;
  - b) the need, if any, for follow-up medical evaluations;
  - c) a statement that the physician or health care professional has provided the employee a copy of the physician's recommendation;
  - d) a copy of NCDA&CS' Physician's Opinion Letter (Appendix C) should also be sent with the employee to the physician to facilitate documentation of the physician's medical determination.

North Carolina Department of Agriculture and Consumer Services

EMPLOYEE RESPIRATOR USE PROFILE

Supplemental Information Issued to Physician or Health Care Professional To Be Completed by Employee's/  
Applicant's Supervisor and Taken To The Physician/Health Care Professional By The Applicant/Employee

Employee/Applicant's Name \_\_\_\_\_

Date \_\_\_\_\_ Site \_\_\_\_\_

1. Type of respirator to be worn

- ˘ ½ face air purifying
- ˘ full face air purifying
- ˘ other (describe) \_\_\_\_\_

2. The subject will wear the respirator (maximum use per month)

- ˘ more than 15 times a month
- ˘ 5-15 times a month
- ˘ 1-4 times a month
- ˘ less than once per month

3. During those times, the respirator will be worn

- ˘ 8 hours/day
- ˘ 4-7 hours/day
- ˘ 1-3 hours/day
- ˘ less than one hour/day

4. The kind of work to be done while wearing the respirator includes:

- ˘ mixing and loading pesticides
- ˘ spraying pesticides
- ˘ painting
- ˘ shop work
- ˘ handling laboratory chemicals
- ˘ other (specify) \_\_\_\_\_  
\_\_\_\_\_

5. In addition to the respirator, the subject may also be wearing the following personal protective equipment:

- |                       |                           |
|-----------------------|---------------------------|
| ˘ face shield         | ˘ water proof rubber suit |
| ˘ safety glasses      | ˘ apron                   |
| ˘ goggles             | ˘ rubber gloves           |
| ˘ coveralls (plastic) | ˘ rubber boots            |
| ˘ coveralls (cotton)  | ˘ safety shoes            |

6. Temperature and humidity conditions may include while wearing respirator:

- ˘ all types of inside and outside temperature and humidity extremes
- ˘ hot, humid weather
- ˘ indoor conditioned air only
- ˘ indoor unconditioned air
- ˘ other (specify) \_\_\_\_\_

Other factors which may cause physical stress to the respirator user:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Information provided by: \_\_\_\_\_ Phone No. \_\_\_\_\_

(Print Name)



NORTH CAROLINA DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

Respirator Medical Recertification Request

Name of Employee \_\_\_\_\_ Date \_\_\_\_\_

Division \_\_\_\_\_ Employee Age \_\_\_\_\_

Site \_\_\_\_\_ Social Security No. \_\_\_\_\_

Job Title \_\_\_\_\_ Home Phone No. \_\_\_\_\_

Type/Brand of Respirator Used:

- ˘ half face            ˘ MSA
- ˘ full face            ˘ GPT
- ˘ dust mask           ˘ Willson
- ˘ Survivair
- ˘ Other \_\_\_\_\_

Specific Contaminants Encountered (pesticides, paint, etc.) \_\_\_\_\_

Reason(s)/observation(s) made for requesting a medical recertification (be specific and detailed).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Person requesting recertification:
- ˘ Employee
  - ˘ Supervisor
  - ˘ Safety Director
  - ˘ Other \_\_\_\_\_

Employee Signature \_\_\_\_\_

Site Manager Signature \_\_\_\_\_

Submit to NCDA&CS Safety Director  
P.O. Box 27647  
Raleigh, North Carolina 27611

- ˘ Approved
- ˘ Not Approved

\_\_\_\_\_  
Signature, NCDA&CS Safety Director

**North Carolina Department of Agriculture  
and Consumer Services**

**Periodic Health Questionnaire**

**CONFIDENTIAL**

Effective Date: April, 1998

Employee Name \_\_\_\_\_  
Location Name \_\_\_\_\_

PART A  
Section 1

1. Date:	
2. Name:	
3. Age (to nearest year):	4. Sex (circle one):    Male        Female
5. Height: _____ _____ ft.    _____ in.	6. Weight _____ lbs.
7. Employed By:	8. Job Title:
9. Phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____	
10. Best time to phone you at this number:	
11. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one):    Yes        No	
12. 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-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).	
13. 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 check “yes” or “no”).

	<b>YES</b>	<b>NO</b>
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had any of the following conditions? . . . . .		
a. Seizures (fits)?	<input type="checkbox"/>	<input type="checkbox"/>
b.. Diabetes (sugar disease)?	<input type="checkbox"/>	<input type="checkbox"/>
c. Allergic reactions that interfere with your breathing?	<input type="checkbox"/>	<input type="checkbox"/>
d. Claustrophobia (fear of closed-in places)?	<input type="checkbox"/>	<input type="checkbox"/>
e. Trouble smelling odors?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had any of the following pulmonary or lung problems? . . . . .		
a. Asbestosis?	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
c. Chronic bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>
d. Emphysema?	<input type="checkbox"/>	<input type="checkbox"/>
e. Pneumonia?	<input type="checkbox"/>	<input type="checkbox"/>
f. Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
g. Silicosis?	<input type="checkbox"/>	<input type="checkbox"/>
h. Pneumothorax (collapsed lung)?	<input type="checkbox"/>	<input type="checkbox"/>
i. Lung cancer?	<input type="checkbox"/>	<input type="checkbox"/>
j. Broken ribs?	<input type="checkbox"/>	<input type="checkbox"/>
k. Any chest injuries or surgeries?	<input type="checkbox"/>	<input type="checkbox"/>
l. Any other lung problem that you have been told about?	<input type="checkbox"/>	<input type="checkbox"/>

	<b>YES</b>	<b>NO</b>
4. Do you currently have any of the following symptoms of pulmonary or lung illness? . . . . .		
a. Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline?	<input type="checkbox"/>	<input type="checkbox"/>
c. Shortness of breath when walking with other people at an ordinary pace on level ground?	<input type="checkbox"/>	<input type="checkbox"/>
d. Have to stop for breath when walking at your own pace on level ground?	<input type="checkbox"/>	<input type="checkbox"/>
e. Shortness of breath when washing or dressing yourself?	<input type="checkbox"/>	<input type="checkbox"/>
f. Shortness of breath that interferes with your job?	<input type="checkbox"/>	<input type="checkbox"/>
g. Coughing that produces phlegm (thick sputum)?	<input type="checkbox"/>	<input type="checkbox"/>
h. Coughing that wakes you early in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
i. Coughing that occurs mostly when you are lying down?	<input type="checkbox"/>	<input type="checkbox"/>
j. Coughing up blood in the last month?	<input type="checkbox"/>	<input type="checkbox"/>
k. Wheezing?	<input type="checkbox"/>	<input type="checkbox"/>
l. Wheezing that interferes with your job?	<input type="checkbox"/>	<input type="checkbox"/>
m. Chest pain when you breathe deeply?	<input type="checkbox"/>	<input type="checkbox"/>
n. Any other symptoms that you think may be related to lung problems?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had any of the following cardiovascular or heart problems? . . . . .		
a. Heart attack?	<input type="checkbox"/>	<input type="checkbox"/>
b. Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
c. Angina?	<input type="checkbox"/>	<input type="checkbox"/>
d. Heart failure?	<input type="checkbox"/>	<input type="checkbox"/>
e. Swelling in your legs or feet (not caused by walking)?	<input type="checkbox"/>	<input type="checkbox"/>
f. Heart arrhythmia (heart beating irregularly)?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
g. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
h. Any other heart problem that you have been told about?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had any of the following cardiovascular or heart symptoms? . . . . .		
a. Frequent pain or tightness in your chest?	<input type="checkbox"/>	<input type="checkbox"/>
b. Pain or tightness in your chest during physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain or tightness in your chest that interferes with your job?	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past two years, have you noticed your heart skipping or missing a beat?	<input type="checkbox"/>	<input type="checkbox"/>
e. Heartburn or indigestion that is not related to eating?	<input type="checkbox"/>	<input type="checkbox"/>
f. Any other symptoms that you think may be related to heart or circulation problems?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you currently take medication for any of the following problems? . . . . .		
a. Breathing or lung problems?	<input type="checkbox"/>	<input type="checkbox"/>
b. Heart trouble?	<input type="checkbox"/>	<input type="checkbox"/>
c. Blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
d. Seizures (fits)?	<input type="checkbox"/>	<input type="checkbox"/>
8. If you have never used a respirator, check this box and go to question 9.) . . . . .		<input type="checkbox"/>
If you have used a respirator, have you ever had any of the following problems?		
a. Eye irritation?	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin allergies or rashes?	<input type="checkbox"/>	<input type="checkbox"/>
c. Anxiety?	<input type="checkbox"/>	<input type="checkbox"/>

- |  | <b>YES</b>               | <b>NO</b>                |
|--|--------------------------|--------------------------|
| d. General weakness or fatigue?  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Any other problem that interferes with your use of a respirator?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? . . . . . | <input type="checkbox"/> | <input type="checkbox"/> |

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece 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.

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 10. Have you ever lost vision in either eye (temporarily or permanently)? . . . . .  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you currently have any of the following vision problems?                      |                          |                          |
| a. Wear contact lenses?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wear glasses?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Color blind?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Any other eye or vision problem?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had an injury to your ears, including a broken ear drum? . . . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you currently have any of the following hearing problems?                     |                          |                          |
| a . Difficulty hearing?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wear a hearing aid?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any other hearing or ear problem?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had a back injury?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you currently have any of the following musculoskeletal problems? . . . . .   |                          |                          |
| a. Weakness in any of your arms, hands, legs, or feet?                               | <input type="checkbox"/> | <input type="checkbox"/> |

	<b>YES</b>	<b>NO</b>
b. Back pain?		<input type="checkbox"/>
		<input type="checkbox"/>
c. Difficulty fully moving your arms and legs?	<input type="checkbox"/>	<input type="checkbox"/>
d. Pain or stiffness when you lean forward or backward at the waist?	<input type="checkbox"/>	<input type="checkbox"/>
e. Difficulty fully moving your head up or down?	<input type="checkbox"/>	<input type="checkbox"/>
f. Difficulty fully moving your head side to side?	<input type="checkbox"/>	<input type="checkbox"/>
g. Difficulty bending at your knees?	<input type="checkbox"/>	<input type="checkbox"/>
h. Difficulty squatting to the ground?	<input type="checkbox"/>	<input type="checkbox"/>
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.?	<input type="checkbox"/>	<input type="checkbox"/>
j. Any other muscle or skeletal problem that interferes with using a respirator?	<input type="checkbox"/>	<input type="checkbox"/>

**Part B.** 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.

**DO NOT** answer these questions before the exam. The physician may or may not ask you these and other questions during the exam.

	<b>YES</b>	<b>NO</b>
1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?	<input type="checkbox"/>	<input type="checkbox"/>

If “yes,” name the chemicals if you know them.

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	<b>YES</b>	<b>NO</b>
3. Have you ever worked with any of the materials, or under any of the conditions, listed below?		
a. Asbestos?		<input type="checkbox"/> <input type="checkbox"/>
b. Silica (e.g., in sandblasting)?	<input type="checkbox"/>	<input type="checkbox"/>
c. Tungsten/cobalt (e.g., grinding or welding this material)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Beryllium?		<input type="checkbox"/> <input type="checkbox"/>
e. Aluminum?		<input type="checkbox"/> <input type="checkbox"/>
f. Coal (for example, mining)?	<input type="checkbox"/>	<input type="checkbox"/>
g. Iron?	<input type="checkbox"/>	<input type="checkbox"/>
h. Tin?	<input type="checkbox"/>	<input type="checkbox"/>
i. Dusty environments?	<input type="checkbox"/>	<input type="checkbox"/>
j. Any other hazardous exposures?	<input type="checkbox"/>	<input type="checkbox"/>

If "yes," describe these exposures: \_\_\_\_\_

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4. List any second jobs or side businesses you have: \_\_\_\_\_

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5. List your previous occupations: \_\_\_\_\_

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6. List your current and previous hobbies: \_\_\_\_\_

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	<b>YES</b>	<b>NO</b>
7. Have you been in the military service?		
If "yes," were you exposed to biological or chemical agents (either in training or combat)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever worked on a HAZMAT team?	<input type="checkbox"/>	<input type="checkbox"/>

**YES**   **NO**

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)?

 

If "yes," name the medications if you know them: \_\_\_\_\_

10. Will you be using any of the following items with your respirator(s)?

- a. HEPA Filters?
- b. Canisters (for example, gas masks)?
- c. Cartridges?

11. How often are you expected to use the respirator(s)?

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

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

 

- a. Light (less than 200 kcal per hour)?

If "yes," how long does this period last during the average shift? \_\_\_\_\_ hours   \_\_\_\_\_ minutes

Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.

- b. Moderate (200 to 350 kcal per hour)?

If "yes," how long does this period last during the average shift? \_\_\_\_\_ hours   \_\_\_\_\_ minutes

Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at truck 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 (about 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? \_\_\_\_\_ hours                      \_\_\_\_\_ minutes

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 up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).13.

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. Will you be working under hot conditions (temperature exceeding 77 deg. F)?                                           

15. Will you be working under humid conditions?                                           

16. Describe the work you'll be doing while you are using your respirator(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. Describe any special or hazardous conditions you might encounter when you are using your respirator(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Provide the following information, if you know it, for each toxic substance that you will be exposed to when you are using your respirator(s):

Name of the **first** toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

Name of the **second** toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

The name of the **third** toxic substance

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

The name of any other toxic substances that you will be exposed to while using your respirator: \_\_\_\_\_  
\_\_\_\_\_

19. Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_