ANNUAL RESPIRATOR QUESTIONNAIRE

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you developed any medical problems or symptoms that may limit your ability to use a respirator since you last filled out the OSHA respirator questionnaire?

Yes No

1. Have you been told by a health care professional, your supervisor, or the respirator program administrator that you should be medically reevaluated since you last filled out the OSHA respirator questionnaire?

Yes No

1. Have you developed any medical signs or symptoms related to respirator usage since you last filled out the OSHA respirator questionnaire?

Yes No

1. Has there been a change in workplace conditions, e.g., physical work effort, protective clothing, temperature, that has resulted in a substantial increase in the physical burden on you since you last filled out the OSHA respirator questionnaire?

Yes No

1. Have you had any changes in facial or neck structures (e.g. weight loss or scarring) since you last filled out the OSHA respirator questionnaire?

Yes No

Please explain any yes answers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Employee Signature Date

**This form will be reviewed by the Occupational Health Department or Medical Provider**

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**Licensed Healthcare Provider Signature Date**

Comments