



# OSHA Respirator Medical Evaluation Questionnaire

Bay Pines VA Medical Center

Respirator Clearance

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN #: \_\_\_\_\_

Gender:  Male  Female Height: \_\_\_\_\_ Weight \_\_\_\_\_ Contact #: \_\_\_\_\_

Service: \_\_\_\_\_ Job Title: \_\_\_\_\_

Check the type of respirator(s) you be using (if known):

- i. N, R, or P Disposable Respirator (Filter-Mask, Non-Cartridge Type Only)  
 ii. Other Type (i.e. Half/Full-Face Piece Type, Powered-Air Purifying, Supplied-Air, Self-Contained Breathing Apparatus)

Have you worn a respirator before:  Yes  No

If Yes, What Type(s): \_\_\_\_\_

FOR EMPLOYEE HEALTH SERVICES OFFICE STAFF USE ONLY

## Approved Respirator Type:

Air-Supplying:

- Positive Pressure: Self Contained Breathing Apparatus (SCBA)  
 Supplied Air (Air line)

Air-Purifying:

- Powered: Tight-Fitting Hood (PAPR)  
 Powered: Loose-Fitting Hood (PAPR)  
 Full-Face Piece  
 Half-Face Piece  
 Filtering Facepiece (i.e. N/R/P) Disposable Mask

\_\_\_\_\_  
Healthcare Provider Signature  
Employee Health Services

\_\_\_\_\_  
Date