Address: 7501 West 15th Avenue
Gary, Indiana 46406
Phone #: (219) 977-2090
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Form CCF1003

Respirator Certification

Employee's Last Name:	First Name:	Pre-Fix	SSN	DOB

Phone #:	Street Address:	City:	State:	Zip Code:

Employer:	Dept:	Job:

Best time to phone: **Height:** ______ **ft** ______ **in** **Weight:** ______ **lbs**

Statement of Patient's Present Health and Medications Currently Used (use additional pages if necessary)

Every employee who has been selected to use any type of respirator must answer the following.

1. Had your employer told you how to contact the healthcare professional who will review this questionnaire? Yes ☐ No ☐
2. Check the type of respirator you will use (you can check more than one category

   ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only)

   ☐ Other type (e.g. half- or full-face piece type, powered-air purifying, supplied- air, self-contained breathing apparatus)

3. Have you worn a respirator? Yes ☐ No ☐

   If yes, what type(s):________________________________

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

5. Have you ever had any of the following conditions?

Condition	Yes	No
Seizures (fits)	☐	☐
Allergic reactions that interfere with your breathing	☐	☐
Trouble smelling odors	☐	☐
Diabetes (Sugar disease)	☐	☐
Claustrophobia (fear of closed-in-places)	☐	☐

6. Have you ever had any of the following pulmonary or lung problems?

Condition	Yes	No
Asbestosis	☐	☐
Emphysema	☐	☐
Silicosis	☐	☐
Broken ribs	☐	☐
Asthma	☐	☐
Pneumonia	☐	☐
Pneumothorax (collapsed lung)	☐	☐
Any chest injuries or surgeries	☐	☐
Chronic bronchitis	☐	☐
Tuberculosis	☐	☐
Lung cancer	☐	☐
Any other lung problem that you've been told about	☐	☐

7. Do you currently have any of the following symptoms of pulmonary or lung disease?

Symptom	Yes	No
Shortness of breath	☐	☐
Shortness of breath when walking fast on level ground or walking up a slight hill	☐	☐
Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
Stopping for breath when walking at your own pace on level ground	☐	☐
Shortness of breath when washing or dressing yourself	☐	☐
Shortness of breath that interferes with your job	☐	☐
Coughing that produces phlegm (thick sputum)	☐	☐
Coughing that wakes you up early in the morning	☐	☐
Coughing that occurs mostly when you are lying down	☐	☐
Coughing up blood in the last month	☐	☐
Wheezing	☐	☐
Wheezing that interferes with your job	☐	☐
Chest pain when you breathe deeply	☐	☐
Any other symptoms that you think may be related to lung problems	☐	☐

8. Have you ever had any of the following cardiovascular of heart problems?

Heart attack	Yes ☐	No ☐	Swelling in legs or feet	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Heart arrhythmia (heart beating irregularly)	Yes ☐	No ☐
Angina	Yes ☐	No ☐	High blood pressure	Yes ☐	No ☐
Heart failure	Yes ☐	No ☐	Any other heart problems that you've been told about	Yes ☐	No ☐

9. Have you ever had any of the following cardiovascular or heart symptoms? Yes ☐ No ☐

Frequent pain or tightness in chest	Yes ☐	No ☐
Pain or tightness in your chest during physical activity	Yes ☐	No ☐
In the past two years have you noticed your heart skipping or missing a beat	Yes ☐	No ☐
Heartburn or indigestion that is not related to eating	Yes ☐	No ☐
Any other symptoms that you think may be related to heart or circulation problems	Yes ☐	No ☐

10. Do you currently take medicine for any of the following problems?

Breathing or lung problems	Yes ☐	No ☐	Heart trouble	Yes ☐	No ☐
Blood pressure	Yes ☐	No ☐	Seizures (fits)	Yes ☐	No ☐

11. If you've used a respirator, have you ever had any of the following problems?
(If you have never used one, check here ☐ and go to the next question.)

Eye irritation	Yes ☐	No ☐	Skin allergies or rashes	Yes ☐	No ☐
Anxiety	Yes ☐	No ☐	General weakness or fatigue	Yes ☐	No ☐
Any other problem that interferes with your use of a respirator				Yes ☐	No ☐

12. Would you like to talk about your answers to this questionnaire with the healthcare professional who will be reviewing it?

Yes ☐ No ☐

Employees who have been selected to use either a full-face piece respirator or a self-contained apparatus (SCBA) must answer the following questions. For employees who have been selected to use other types of respirators, answering these questions is voluntary.

13 Have you ever lost vision in either eye (temporarily or permanently)? Yes ☐ No ☐

14 Do you currently have any of the following vision problems?

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

15 Have you ever had a back injury? Yes ☐ No ☐

16 Do you currently have an of the following musculoskeletal problems?

Weakness in any of your arms, hands, legs, or feet	Yes ☐	No ☐
Back pain	Yes ☐	No ☐
Difficulty fully moving your arms and legs	Yes ☐	No ☐
Pain or stiffness when you lean forward or backward at the waist	Yes ☐	No ☐
Difficulty fully moving your head up or down	Yes ☐	No ☐
Difficulty bending at your knees	Yes ☐	No ☐
Difficulty squatting to the ground	Yes ☐	No ☐
Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.	Yes ☐	No ☐
Any other muscle or skeletal problem that interferes with using a respirator	Yes ☐	No ☐