



RESPIRATOR USER SCREENING FORM

Part 1: RESPIRATOR USER INFORMATION

Name (first and last):		Employee/Student #:	
Department/School		Job Title/Course:	
Contact Info	BCIT Email:	BCIT Phone #:	

Part 2: CONDITIONS OF USE

ACTIVITIES requiring respirator use:	
FREQUENCY of respirator use:	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other
EXERTION level during use:	<input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Other
DURATION of respirator use per shift:	<input type="checkbox"/> <1/4 h <input type="checkbox"/> >1/4 h <input type="checkbox"/> >2 h <input type="checkbox"/> Variable <input type="checkbox"/> Other
TEMPERATURE during use:	<input type="checkbox"/> < 0°C <input type="checkbox"/> 0 - 25°C <input type="checkbox"/> > 25°C
Additional types of personal protective equipment required (specify):	
Estimated total weight of tools/equipment carried during respirator use:	Maximum: _____ Average: _____

Part 3: TYPES OF RESPIRATOR USED (check all that apply)

<input type="checkbox"/> N95 <input type="checkbox"/> Half facepiece respirator <input type="checkbox"/> Full facepiece respirator <input type="checkbox"/> SCBA <input type="checkbox"/> Airline <input type="checkbox"/> Non-tight fitting (e.g. hood PAPR) <input type="checkbox"/> Other (specify): _____
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Part 4: RESPIRATOR USER'S HEALTH CONDITIONS

Check Yes or No box only. DO NOT specify. NOTE: Medical information is NOT to be offered on this form.

a) Some conditions can seriously affect your ability to safely use a respirator. Do you have or do you experience any of the following or any other condition that could affect respirator use?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	Breathing difficulties	Chronic Bronchitis	Emphysema	
Lung Disease	Chest Pain on Exertion	Heart Problems	Allergies	
Hypertension	Cardiovascular Disease	Thyroid Problems	Diabetes	
Neuromuscular Disease	Fainting Spells	Dizziness/Nausea	Seizures	
Temperature Sensitivity	Claustrophobia/Height Fears	Hearing Impairment	Pacemaker	
Panic Attacks	Colour Blindness	Asthma	Vision Impairment	
Reduced Sense of Smell	Reduced Sense of Taste	Back/Neck Problems	Unusual facial features	
Unusual Skin Conditions	Dentures	Other Conditions that may affect respirator use	Prescription medication that may affect respirator use	
b) Have you had previous difficulty while using a respirator				<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Do you have any concerns about your future ability to use a respirator safely?				<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Have you ever had a severe adverse health reaction or condition while undergoing a fit testing process?				<input type="checkbox"/> Yes <input type="checkbox"/> No
e) If you got a fit test last year at BCIT to the same type of respirator and you checked "Yes" to a), has your condition changed from last year?				<input type="checkbox"/> Yes <input type="checkbox"/> No

A "YES" answer to a), b), c), d), or e) indicates further assessment by a health care professional is required prior to respirator use. Notify your fit tester for next steps. You do not need to indicate specifically which of the above conditions apply or describe any of your personal health details.

COMPLETE THIS SECTION ONLY IF YOU HAVE PREVIOUSLY GOT FIT TESTED AT BCIT AND HAD TO GO TO A HEALTH CARE PROFESSIONAL FOR AN ASSESSMENT:

If you got a fit test before at BCIT to the same type of respirator that you want to be fit tested to now, and a health care professional has already assessed your suitability to wear a respirator based on health conditions that you previously identified, then you do not need to get another assessment by a health care professional. If this is the case, please indicate "Yes".	<input type="checkbox"/> Yes <input type="checkbox"/> My condition has changed, or I have a new condition
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Signature of respirator user: _____

Date: _____

SUBMIT COMPLETED COPY OF THIS FORM TO YOUR FIT TESTER BY EMAIL PRIOR TO YOUR FIT TEST APPOINTMENT

BCIT EMPLOYEES: CC: SSEMhse@bcit.ca ON FORM SUBMISSIONS