PROVIDENCE
Regional Medical Center
Everett

Employee Health & Wellness
Non-Employee Information Sheet

Personal Information

Last Name				**SSN #**	LEAVE BLANK
First Name				**Middle**	
Date of Birth				**Sex**	Male Female
Address					
	City		**State**	**Zip Code**	
Phone Number	( )				
Email					
I am a(n)	MD/DO/PA/ARNP	Contract Staff	Volunteer	Intern/Student	
Job Title					
Department or Unit					
Primary Work Location	Colby	Pacific	Broadway	Other:_____	
	Full-time	Part-Time	Temporary: □ < 6 mo	□ > 6 mo	

Parental Permission (17 years old and younger)

Parent or Legal Guardian's Name	
Phone Number	( )
I give Providence Regional Medical Center (PRMCE) permission to administer and read a Tuberculosis Skin Test and/or perform a blood test to determine immunity to Measles, Mumps, Rubella, and Chicken Pox.	
Signature and Date	

Providence St. Joseph Health

RESPIRATORY PROTECTION TESTING/TRAINING FORM

Ministry Location:_____

Caregiver Name: (Last, First)	ID Number: DOB:
Position:	Department:

I acknowledge that have had no changes to my medical condition **(e.g. cardiovascular or pulmonary issues, seizures or claustrophobia)** or changes in workplace conditions that would affect my ability to use a respirator safely.

☐ **YES** ☐ **NO** **Caregiver Initial:** _____

Fit test conductor instructions

- Do not fit test if any change in medical condition noted above. Contact Caregiver Health Services.
- Complete fit testing and return signed form ASAP to Caregiver Health Services
- Provide caregiver with proof of testing
- Contact Caregiver Health Services for questions or how to order supplies

1. **Method:** ☐ **Quantitative Test (Portacount)** ☐ **Qualitative Test (Bitrex/Saccharin) - Test Solution Sensitivity:** ☐ Pass ☐ Fail
   NOTE: If caregiver cannot taste the dilute test solution, caregiver is unable to be fit tested.
   ☐ PAPR training or Quantitative test is recommended
2. **Positive pressure seal check:** ☐ Pass ☐ Fail & **Negative pressure seal check:** ☐ Pass ☐ Fail

Exercises Perform each exercise for 60 second	**Respirator Type** _____	**Respirator Type** _____	**Respirator Type** _____
☐ **Qualitative test (Bitrex): check when complete**	☐ **Quantitative test: enter Portacount fit factor**		
Normal breathing			
Deep breathing			
Turning head side to side			
Moving head up and down			
Talking: Read the Rainbow Passage; count backward from 100; sing or talk continuously			
Bending over or jogging in place			
Normal breathing (again)			

RESPIRATOR SELECTED

N95 Type: **Size:**	**PAPR:** **Make/Model**

Testing Results:

- ☐ **PASS:** Required to be fit tested annually, or contact Caregiver Health to change to a different respirator size due to changes in weight, facial structure, and/or facial hair.
- ☐ **FAIL:** Unable to obtain a fit and **NOT CLEARED** to wear the N-95 respirator.
- ☐ **Not Tested/Facial Hair**: Fit test CANNOT be conducted due to moustache, stubble, sideburns, bangs, hairline, and other types of facial hair are in areas where the respirator face-piece seals.
- ☐ **Not Tested:** Change in medical condition noted above, refer to Caregiver Health Services.
- ☐ **PAPR Only (Powered Air Purifying Respirator):** For those who failed fit testing or may not be able to be fit tested, and for anyone requesting an accommodation to wear PAPR only if they are not working in a procedural area.

PAPR Training Completed: ☐ **YES** – Date:_____ ☐ **NO** – Date Scheduled:_____

Conductor: (Print/Signature): _____/_____ **Date:** _____

Caregiver Signature _____ **Date:** _____

Providence St. Joseph Health

Caregiver Health Services
Respiratory Protection Program Health History

This questionnaire is used in determining whether or not you have a health condition that may affect your ability to safely wear a respirator. We anticipate being able to approve most caregivers for respiratory use based on this questionnaire alone. In some cases we may ask for more information or additional medical testing/evaluation.

ALL HEALTH INFORMATION IS CONSIDERED CONFIDENTIAL.

Name: _____ **DOB:** _____ **Age:** _____ **Gender:** ❑M ❑F
Last First Middle

Ht: _____ **Wt:** _____ **Job Title:** _____ **Phone #:** _____ **Caregiver ID #:** _____

1. Has your employer told you how to contact the health care professional who will review this questionnaire?
   ❑ **Yes** ❑ **No**

2. Check the type(s) of respirator(s) you will be using. Check all that apply.
   ❑Powered air-purifying cartridge respirator (PAPR) ❑Full face piece mask ❑Helmet hood
   ❑N-95 filtering face piece respirator
   ❑OTHER _____

3. Have you worn a respirator? ❑ **Yes** ❑ **No** If yes what type? _____

Health History Data (Mandatory) Questions 1 through 9 below must be answered by every caregiver who has been selected to use any type of respirator

1. Have you ever had any heat-related illnesses (e.g. heat stroke, heat exhaustion)? ❑ **Yes** ❑ **No**

2. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ❑ **Yes** ❑ **No**

3. Have you ever had any of the following conditions?
   ❑ **Yes** ❑ **No** Seizures
   ❑ **Yes** ❑ **No** Claustrophobia
   ❑ **Yes** ❑ **No** Allergic reactions that interfere with breathing: _____
   ❑ **Yes** ❑ **No** Diabetes
   ❑ **Yes** ❑ **No** Trouble smelling odors

4. Have you ever had any of the following pulmonary or lung problems?
   ❑ **Yes** ❑ **No** Asbestosis
   ❑ **Yes** ❑ **No** Silicosis
   ❑ **Yes** ❑ **No** Asthma
   ❑ **Yes** ❑ **No** Chronic bronchitis
   ❑ **Yes** ❑ **No** Emphysema
   ❑ **Yes** ❑ **No** Any chest injuries or surgeries? _____
   ❑ **Yes** ❑ **No** Any other lung problems that you've been told about? _____
   ❑ **Yes** ❑ **No** Pneumonia
   ❑ **Yes** ❑ **No** Tuberculosis
   ❑ **Yes** ❑ **No** Pneumothorax
   ❑ **Yes** ❑ **No** Lung cancer
   ❑ **Yes** ❑ **No** Broken ribs

5. Do you currently have any of the following symptoms of pulmonary or lung illness?
   ❑ **Yes** ❑ **No** Shortness of breath
   ❑ **Yes** ❑ **No** Shortness of breath when walking fast on level ground or walking up a slight hill or incline

❑ Yes ❑ No Shortness of breath when walking with other people at an ordinary pace on level ground
❑ Yes ❑ No Have to stop for breath when walking at your own pace on level ground
❑ Yes ❑ No Shortness of breath when washing or dressing yourself
❑ Yes ❑ No Shortness of breath that interferes with your job
❑ Yes ❑ No Coughing that produces phlegm
❑ Yes ❑ No Coughing that wakes you early in the morning
❑ Yes ❑ No Coughing that occurs mostly when you are lying down
❑ Yes ❑ No Coughing up blood in the last month
❑ Yes ❑ No Wheezing
❑ Yes ❑ No Wheezing that interferes with your job
❑ Yes ❑ No Chest pain when you breathe deeply
❑ Yes ❑ No Any other symptoms that you think may be related to lung problems? _____

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

❑ Yes ❑ No Heart attack
❑ Yes ❑ No High blood pressure
❑ Yes ❑ No Angina
❑ Yes ❑ No Swelling of your legs or feet (not caused by walking)
❑ Yes ❑ No Any other heart problem that you've been told about? _____
❑ Yes ❑ No Heart arrhythmia
❑ Yes ❑ No Stroke
❑ Yes ❑ No Heart failure

7. Have you ever had any of the following cardiovascular or heart symptoms?

❑ Yes ❑ No Frequent pain or tightness in your chest
❑ Yes ❑ No Pain or tightness in your chest during physical activity
❑ Yes ❑ No Pain or tightness in your chest that interferes with your job
❑ 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? ____

8. Do you currently take medication for any of the following problems?

❑ Yes ❑ No Breathing or lung problems
❑ Yes ❑ No Blood pressure
❑ Yes ❑ No Heart trouble
❑ Yes ❑ No Seizures

9. If you've used a respirator, have you ever had any of the following problems?

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

10. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? ❑ Yes ❑ No

I understand the questions and had an opportunity to ask questions concerning the health history related to Respiratory Protection Program and Fit Testing.

Signature of caregiver: _____ **Date:** _____