

APPENDIX 1

N95 MASK FIT TESTING – HEALTH SCREENING QUESTIONNAIRE

This information is required to assess any medical conditions that you may have which would preclude the wearing of a respirator. Further medical examination by a physician shall be required if this initial assessment determines the need for medical clearance to wear a respirator. The information requested on this form is collected under the authority of Section 33(c) of the Alberta *Freedom of Information and Protection of Privacy Act* for the purpose of *early illness intervention through medical surveillance*. Questions about the collection, use or disposal of this information should be directed to: Environment, Health and Safety at 403-220-6345 or fax 403-284-1332.

Section 1.0 and 2.0 to be completed by the worker.

1.0 Worker Information		
Last Name:	First Name:	Email:
UCID# or Driver's license number:	Work Contact Number:	Work Address:
Department:	Job Title:	Supervisor Name:
Supervisor Contact Number:	Supervisor Work Address:	Supervisor Email:

2.0 Respirator User's Health Condition			
For the following questions check the yes or no box only. Do not specify any medical condition.			
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 another condition which may affect respirator use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Shortness of breath	Breathing difficulties	Chest pain on exertion	Diabetes
Lung disease	Chronic bronchitis	Asthma	Neck problems
High blood pressure	Heart problems	Pacemaker	Heat stroke
Fainting spells	Panic attacks	Seizure	Heat exhaustion
Vision impairment	Color blindness	Dentures	Skin conditions
Reduced sense of smell	Reduce sense of taste	Hearing impairment	Prescription medication
Altered facial features	Muscle weakness	Back problems	Claustrophobia
Persistent cough	Emphysema	Dizziness	Latex allergy or sensitization
b) Have you had any previous difficulty while using a respirator?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
c) Do you have any concern about your future ability to wear a respirator?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
A 'YES' response to either a), b), or c) above indicates that further assessment is required by a physician prior to respirator use. NOTE: Medical information is not to be offered on this form.			

I have answered the questions truthfully, to the best of my ability and knowledge. I agree to report to my department/faculty, Environment, Health & Safety and my physician any change in my physical health that might affect my ability to wear a respirator. I consent to allow my Health Care Practitioner to send information regarding my fitness to wear a respirator to my Supervisor and to Environment, Health and Safety. Please note: this consent expires in one (1) year from date signed.

Signature – Respirator Wearer	
Name (Printed):	Department:
Signature:	Date:

Health Screening Questionnaire is considered confidential medical information and is to be sent by the worker/student to the Wellness Centre.