



CUI/With Entry

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Issue No. 020

Medical Clearance for Respirator Use
(Reference MNL-352259 and 29 CFR 1910.134 Appendix C)

PLEASE PRINT OR TYPE YOUR ANSWERS:

Full Name: _____ Badge#: _____ Dept#: _____
Plant Address: _____ Phone: _____ Pager: _____
Supervisor: _____ Shift: _____ Age: _____
Job Title: _____ Sex: [] M [] F Date of Birth: _____

Are you an Emergency Response Team member? [] Yes [] No

Check all that apply: [] Radiation Accident Team (RAT) [] Accident Response Group (ARG)
[] Spill Team [] Auxiliary (AUX) Guard [] Fire Brigade

Has your employer told you how to contact the health care professional who will review this questionnaire? [] Yes [] No

You may discuss your questions during your physical or call (806) 573-1396 for an appointment.

Check the type of respirator you will use. You can check more than one category.

- [] Filter face piece (ex. Dust-mask).
[] Air-purifying (ex. Dual cartridge: half- or full-face type).
[] Air-supplied (ex. self-contained breathing apparatus (SCBA) or powered-air purifying).

Have you worn a respirator? [] Yes [] No

How many times per day ____, per week ____, per month ____ Do you wear a respirator?

How many minutes at a time do you wear the Respirator? ____

What is your level of work while wearing the respirator? Check ALL that apply:

- [] Light (sweeping floors, bench work, parts inspection, etc.).
[] Medium (moving small to medium-sized loads, operating machinery, etc.).
[] Heavy (construction, digging, lifting heavy objects, etc.).

Will you wear any additional Personal Protective Equipment (PPE) at the same time with the respirator? If YES, what type? _____ [] Yes [] No

Controlled By: Environment Safety & Health
POC: Alex Saldivar, alex.saldivar@pantex.doe.gov
Pantex eDC/RO ID: 975562
Date Reviewed: 4/23/2026



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MEDICAL EVALUATION

Full Name: Badge#: Dept#:

- Approved with NO Restrictions
Approved with the following Restrictions:
Half Mask Only Light Weight SCBA No SCBA Powered Air Purifying Respirator (PAPR) Only

Other:

- Not Approved for respirator use.

COMMENTS:

Large empty rectangular box for comments.

Print/Type Clinician Name DO MD NP PA Clinician Signature Date



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PLEASE PRINT OR TYPE YOUR ANSWERS:

Full Name: _____ Badge#: _____

Your Height: _____ feet _____ inches Your Weight: _____ Pounds

Occupational Safety and Health Act (OSHA) Respirator Medical Evaluation Questionnaire

Can you read? Yes No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor **must not** look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

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

2. Have you **ever had** any of the following conditions?

- a. Seizures (fits): Yes No
- b. Diabetes (sugar disease): Yes No
- c. Allergic reactions that interfere with your breathing: Yes No
- d. Claustrophobia (fear of closed-in places): Yes No
- e. Trouble smelling odors: Yes No

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

- a. Asbestosis: Yes No
- b. Asthma: Yes No
- c. Chronic bronchitis: Yes No
- d. Emphysema: Yes No
- e. Pneumonia: Yes No
- f. Tuberculosis: Yes No
- g. Silicosis: Yes No
- h. Pneumothorax (collapsed lung): Yes No
- i. Lung cancer: Yes No
- j. Broken ribs: Yes No
- k. Any chest injuries or surgeries: Yes No
- l. Any other lung problem that you have been told about: Yes No



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4. Do you currently have any of the following symptoms of pulmonary or lung illness?
- a. Shortness of breath: _____ Yes No
 - b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: _____ Yes No
 - c. Shortness of breath when walking with other people at an ordinary pace on level ground: _____ Yes No
 - d. Have to stop for breath when walking at your own pace on level ground: _____ Yes No
 - e. Shortness of breath when washing or dressing yourself: _____ Yes No
 - f. Shortness of breath that interferes with your job: _____ Yes No
 - g. Coughing that produces phlegm (thick sputum): _____ Yes No
 - h. Coughing that wakes you early in the morning: _____ Yes No
 - i. Coughing that occurs mostly when you are lying down: _____ Yes No
 - j. Coughing up blood in the last month: _____ Yes No
 - k. Wheezing: _____ Yes No
 - l. Wheezing that interferes with your job: _____ Yes No
 - m. Chest pain when you breathe deeply: _____ Yes No
 - n. Any other symptoms that you think may be related to lung problems: _____ Yes No
5. Have you ever had any of the following cardiovascular or heart problems?
- a. Heart attack: _____ Yes No
 - b. Stroke: _____ Yes No
 - c. Angina: _____ Yes No
 - d. Heart failure: _____ Yes No
 - e. Swelling in your legs or feet (not caused by walking): _____ Yes No
 - f. Heart arrhythmia (heart beating irregularly): _____ Yes No
 - g. High blood pressure: _____ Yes No
 - h. Any other heart problem that you have been told about: _____ Yes No
6. Have you ever had any of the following cardiovascular or heart symptoms?
- a. Frequent pain or tightness in your chest: _____ Yes No
 - b. Pain or tightness in your chest during physical activity: _____ Yes No
 - c. Pain or tightness in your chest that interferes with your job: _____ Yes No
 - d. In the past two years, have you noticed your heart skipping or missing a beat: _____ Yes No
 - e. Heartburn or indigestion that is not related to eating: _____ Yes No
 - f. Any other symptoms that you think may be related to heart or circulation problems: _____ Yes No
7. Do you currently take medication for any of the following problems?
- a. Breathing or lung problems: _____ Yes No
 - b. Heart trouble: _____ Yes No
 - c. Blood pressure: _____ Yes No
 - d. Seizures (fits): _____ Yes No



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If you have never used a respirator, check the following space and go to Question 9: [] Never Used

- 8. If you have used a respirator, have you ever had any of the following problems?
a. Eye irritation: [] Yes [] No
b. Skin allergies or rashes: [] Yes [] No
c. Anxiety: [] Yes [] No
d. General weakness or fatigue: [] Yes [] No
e. Any other problem that interferes with your use of a respirator: [] Yes [] No
9. Would you like to talk about your answers to this questionnaire with the healthcare professional who will review it? [] Yes [] No

Every employee selected to use either a full-facepiece respirator or a SCBA must answer Questions 10 to 15, below. For employees selected to use other types of respirators, answering these questions is voluntary.

ALL NEW HIRE EMPLOYEES MUST ANSWER ALL QUESTIONS 10 TO 15.

10. Have you ever lost the vision in either eye (temporarily or permanently)? [] Yes [] No

- 11. Do you currently have any of the following vision problems?
a. Wear contact lenses: [] Yes [] No
b. Wear glasses: [] Yes [] No
c. Color blind: [] Yes [] No
d. Any other eye or vision problem: [] Yes [] No

12. Have you ever had an injury to your ears, including a broken eardrum? [] Yes [] No

- 13. Do you currently have any of the following problems?
a. Difficulty hearing: [] Yes [] No
b. Wear a hearing aid: [] Yes [] No
c. Any other hearing or ear problem: [] Yes [] No

14. Have you ever had a back injury? [] Yes [] No

- 15. Do you currently have any of the following musculoskeletal problems?
a. Weakness in any of your arms, hands, legs, or feet: [] Yes [] No
b. Back pain: [] Yes [] No
c. Difficulty fully moving your arms and legs: [] Yes [] No
d. Pain or stiffness when you lean forward or backward at the waist: [] Yes [] No
e. Difficulty fully moving your head up or down: [] Yes [] No
f. Difficulty fully moving your head side to side: [] Yes [] No
g. Difficulty bending at your knees: [] Yes [] No
h. Difficulty squatting to the ground: [] Yes [] No
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: [] Yes [] No
j. Any other muscle or skeletal problem that interferes with using a respirator: [] Yes [] No

All employees please continue on following page.



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16. List any second jobs or side businesses you have:

17. List your previous occupations:

18. List your current and previous hobbies:

19. Have you been in the military services? Yes No

If YES, were you exposed to biological or chemical agents, either in training or combat? Yes No

20. Have you ever worked on a HAZMAT team? Yes No

21. Have you ever worked with any of these materials, or under any of the conditions listed below?

- Asbestos Yes No
- Aluminum Yes No
- Beryllium Yes No
- Coal (e.g., mining) Yes No
- Dusty environments Yes No
- Iron Yes No
- Silica (e.g., in sandblasting) Yes No
- Tin Yes No
- Tungsten/cobalt (e.g., grinding or welding this material) Yes No
- Any other hazardous exposures? Yes No

Please describe these exposures: _____

Signature (person completing form): _____ Date: _____