

Annual Firefighter Physical Exam Packet**FORM PKT-02****ANNUAL MEDICAL EVALUATION • RESPIRATOR CLEARANCE • AUDIOMETRIC TESTING • SCBA FIT TEST**

FIREFIGHTER NAME

SSN / EMPLOYEE ID

FIRE DEPARTMENT

RANK / POSITION

STATION / SHIFT

YEARS OF SERVICE

DATE OF SERVICE

EXAM TYPE

☐ Annual ☐ Pre-Placement ☐ Return-to-Duty ☐ Post-Incident

SCBA / RESPIRATOR ASSIGNED

PACKET CONTENTS

#	FORM	FORM #	COMPLETED BY	✓
01	Patient Registration & Consent for Evaluation	MC-100	Firefighter	☐
02	Consent / Authorization for Disclosure of PHI	MC-101	Firefighter	☐
03	Medical History Questionnaire	MC-102	Firefighter	☐
04	Orthopedic History Questionnaire	MC-103	Firefighter	☐
05	Physical Examination	MC-104	Provider	☐
06	OSHA Respirator Medical Evaluation (4 pages)	MC-105	Firefighter	☐
07	Pulmonary Function Testing Report	MC-106	Provider	☐
08	Audiogram	MC-107	Provider	☐
09	Respirator Fit Test Record	MC-108	Provider	☐
10	Return to Work / School Release	MC-109	Provider	☐

BEFORE YOU BEGIN

- Complete every page. Do not detach pages — this packet is scanned and filed as a single record.
- Print clearly in blue or black ink. Answer every question; enter “N/A” where one does not apply.
- Firefighter-completed forms must be signed and dated by the firefighter; provider forms by the examining clinician.
- The OSHA respirator questionnaire is confidential. Your department or officer may not review your answers — return it directly to MedCare.
- Bring your assigned SCBA facepiece make, model and size to the appointment so the fit test record can be completed.
- Questions? Call MedCare Occupational Health at +1 956-233-2103 or email medcareocc@gmail.com.

FOR MEDCARE USE ONLY

RECEIVED BY

DATE RECEIVED

PACKET COMPLETE

☐ YES ☐ NO

REVIEWING PROVIDER

CLEARANCE DETERMINATION

Patient Registration & Consent for Evaluation

FORM MC-100

PATIENT INFORMATION

PATIENT NAME

DRIVER LICENSE #

DATE OF BIRTH

GENDER

☐ Male ☐ Female

HOME ADDRESS

CITY, STATE, ZIP

PHONE #

EMAIL

EMERGENCY PHONE #

BARCODE / CHAIN OF CUSTODY #

REASON FOR VISIT**SERVICES REQUESTED**☐ Urine Drug Test (UDT)☐ Pre-Employment Physical Examination (PEP)☐ Hair Follicle Drug Test (HFDT)☐ DOT Physical Examination (DOT PE)☐ Oral Fluid Drug Test (OFDT)☐ Non-DOT Physical Examination (NDP)☐ Breath Alcohol Test (BAT)☐ HAZWOPER Medical Examination (HME)☐ Random Drug Test (RDT)☐ Firefighter Medical Examination (FME)☐ Blood Collection (BC)☐ Return to Work Evaluation (RTW)☐ Medical Weight Management (MWM)☐ Audiogram / Hearing Test (AUD)☐ Respirator Fit Test (RFT)**CONSENT FOR EVALUATION AND TREATMENT**

I hereby consent to receive medical evaluation, treatment, and related occupational health services as deemed necessary by the licensed healthcare provider at MedCare Occupational Health PLLC. I understand that these services are provided for employment and occupational purposes, and that relevant results may be shared with my employer or their designated representative as permitted by law. I acknowledge that care provided by MedCare Occupational Health PLLC does not replace the medical care of my personal physician.

PATIENT SIGNATURE

DATE

Consent / Authorization for Disclosure of PHI

FORM MC-101

PURSUANT TO 45 CFR 164.508

PATIENT IDENTIFICATION

FIRST NAME	LAST NAME		SSN / EMPLOYEE ID	
DATE OF BIRTH	AGE	SEX ☐ Male ☐ Female	TODAY'S DATE	
ADDRESS		CITY	STATE	ZIP
CELL / HOME PHONE		WORK PHONE	EMAIL	

AUTHORIZATION

I HEREBY AUTHORIZE (CLINIC NAME)

CLINIC ADDRESS

to disclose medical information and/or protected health information (PHI) of the patient listed above to:

MedCare Occupational Health PLLC

31047 State Highway 100, Los Fresnos, TX 78566 · Phone +1 956-233-2103 · medcareocc@gmail.com

PURPOSE Evaluation requested by employer or prospective employer.

TREATMENT DATE(S) FROM _____ THROUGH _____

THIS AUTHORIZATION EXPIRES UPON THE FOLLOWING DATE OR EVENT _____

ACKNOWLEDGEMENTS

- If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Custodian of Records of the above facility. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.
- Fees/charges will comply with all laws and regulations applicable to release of information.
- I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
- I specifically authorize written, oral and telefax communications with MedCare Occupational Health.
- I understand and agree that the results will be disclosed to my Company's representative and/or Medical Review Officer and hereby release MedCare Occupational Health, any employees and/or agents thereof from any and all claims or causes of actions resulting from the disclosure of these results. Additionally, in accordance with Federal Regulations, the Medical Review Officer is authorized to verify medical information supplied by me under the Department of Health and Human Services Mandatory Guidelines for Federal Workplace Drug Testing Programs (this information may include medical records from a hospital, my personal physician, dentist, or pharmacy records).

INITIAL I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results and/or AIDS information.

I have read the above and authorize the disclosure of the protected health information as stated.

SIGNATURE

DATE

Medical History Questionnaire

FORM MC-102

FIRST NAME

LAST NAME

SSN / EMPLOYEE ID

DATE OF BIRTH

AGE

SEX

☐ Male ☐ Female

TODAY'S DATE

PRESENT OCCUPATION

COMPANY

MEDICAL HISTORY

Mark every line. If you answer YES to any item, explain it in the space below.

CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N
Asthma / wheezing	☐	☐	Heart trouble	☐	☐	Neck pain	☐	☐
Pneumonia	☐	☐	Palpitation / pounding heart	☐	☐	Back pain / injury	☐	☐
Tuberculosis / lung disease	☐	☐	Pain / pressure in chest	☐	☐	Fractured / broken bones	☐	☐
Frequent bronchitis	☐	☐	High blood pressure	☐	☐	Swollen / stiff / painful joints	☐	☐
Shortness of breath	☐	☐	Diabetes	☐	☐	Amputations	☐	☐
Chronic cough	☐	☐	Stroke	☐	☐	Deformities of legs, feet, arms, hands, back or joints	☐	☐
Coughing up blood	☐	☐	Rheumatic fever	☐	☐	Loss of appetite	☐	☐
Sleep apnea / loud snoring	☐	☐	Bleeding disorder or issue	☐	☐	Unexplained weight change	☐	☐
Glasses / contacts	☐	☐	Inflammation of veins / clots	☐	☐	Tumors / abnormal growths	☐	☐
Glaucoma	☐	☐	Enlarged / varicose veins	☐	☐	Thyroid problems	☐	☐
Eye injury / operation / defects	☐	☐	Nausea / vomiting (frequent)	☐	☐	Hernia	☐	☐
Loss of hearing / ringing in ears	☐	☐	Vomiting up blood	☐	☐	Hemorrhoids	☐	☐
Headaches (frequent / severe)	☐	☐	Ulcer(s)	☐	☐	Venereal disease(s)	☐	☐
Head injury	☐	☐	Diarrhea (frequent / severe)	☐	☐	Allergies (drug, hay fever, food)	☐	☐
Blackouts / dizziness / fainting	☐	☐	Constipation (frequent / severe)	☐	☐	Currently taking medications	☐	☐
Epilepsy / seizures	☐	☐	Blood in bowel movement	☐	☐	Previous surgery(s)	☐	☐
Nervous disorders	☐	☐	Gallbladder trouble	☐	☐	Other illness or injury	☐	☐
Fear of heights	☐	☐	Kidney / bladder problems	☐	☐	Other: _____	☐	☐
Claustrophobia	☐	☐	Liver disease	☐	☐	Other: _____	☐	☐
Skin conditions	☐	☐	Cancer	☐	☐			

EXPLANATION OF ALL "YES" ANSWERS

LIFESTYLE & WORK HISTORY

	Y	N	IF YES
Current or former smoker	☐	☐	Packs a day? _____ For how many years? _____ If former, how long ago did you quit? _____
Do you drink alcoholic beverages?	☐	☐	Drinks per week? _____ What type(s)? _____
Have you ever had a drug or alcohol problem?	☐	☐	Please explain: _____

	Y	N	IF YES
Have you ever been injured at work?	☐	☐	Please explain: _____ Company name & address: _____
Have you ever received worker's comp benefits?	☐	☐	Please list: _____
Have you ever been placed on light duty from an injury?	☐	☐	Please explain: _____
Has any injury or illness left you with a physical limitation?	☐	☐	Please explain: _____

I understand that failure to answer truthfully may result in the denial of compensation benefits, including medical treatment and expenses. I hereby certify that the information provided above and the information which I will provide to the medical provider in connection with this examination is true and correct to the best of my knowledge. I understand that any omission of fact or false statement is sufficient grounds for denial of employment or, if employed, termination of my employment.

EMPLOYEE SIGNATURE

DATE

Orthopedic History Questionnaire

FORM MC-103

FIRST NAME	LAST NAME	SSN / EMPLOYEE ID
DATE OF BIRTH	AGE	SEX ☐ Male ☐ Female
PRESENT OCCUPATION	COMPANY	

MUSCULOSKELETAL HISTORY

Have you ever had pain in, or injured, any of the following?

BODY AREA	INJURED?	WHERE DID IT HAPPEN?	DATES, TREATMENT GIVEN, HOW LONG IT PERSISTED
Neck	☐ YES ☐ NO	☐ Home ☐ Work	_____
Shoulder	☐ YES ☐ NO	☐ Home ☐ Work	_____
Back	☐ YES ☐ NO	☐ Home ☐ Work	_____
Hand	☐ YES ☐ NO	☐ Home ☐ Work	_____
Knee	☐ YES ☐ NO	☐ Home ☐ Work	_____
Foot	☐ YES ☐ NO	☐ Home ☐ Work	_____

ORTHOPEDIC CARE & RESTRICTIONSHave you ever had surgery on your back, neck, or other orthopedic surgery? ☐ YES ☐ NO

Date(s): _____ Type of surgery: _____

Are you currently taking any medication for a back, neck or other orthopedic injury? ☐ YES ☐ NO

Medication(s): _____

Are you currently under the care of a physician, physical therapist, chiropractor, or pain management specialist? ☐ YES ☐ NO

Provider name: _____ Provider phone: _____

Have you had any restrictions placed on you, current or past, due to a back, neck or other orthopedic injury? ☐ YES ☐ NO

Please list: _____

Have you experienced numbness or tingling, current or past, in your upper or lower extremities due to an injury? ☐ YES ☐ NO

Please explain: _____

I understand that failure to answer truthfully may result in the denial of compensation benefits, including medical treatment and expenses. I hereby certify that the information provided above and the information which I will provide to the medical provider in connection with this examination is true and correct to the best of my knowledge. I understand that any omission of fact or false statement is sufficient grounds for denial of employment or, if employed, termination of my employment.

EMPLOYEE SIGNATURE

DATE

Physical Examination

FORM MC-104

FIRST NAME

LAST NAME

SSN / EMPLOYEE ID

DATE OF BIRTH

AGE

SEX

☐ Male ☐ Female

TODAY'S DATE

VITAL SIGNS

HEIGHT (IN)

WEIGHT (LB)

BLOOD PRESSURE

PULSE

RESP. RATE

TEMP

REPEAT BP

ARM

REPEAT PULSE

TIME

CLINICIAN

____ / ____

☐ L ☐ R

____ / ____

☐ L ☐ R**SYSTEMS REVIEW**

SYSTEM	NORMAL	ABNORMAL	COMMENTS
General Appearance	☐	☐	
Skin	☐	☐	
Lymphatics	☐	☐	
Muscular Development	☐	☐	
Eyes	☐	☐	
Ears	☐	☐	
Nose	☐	☐	
Throat	☐	☐	
Teeth / Oral Hygiene	☐	☐	
Chest	☐	☐	
Heart	☐	☐	
Lungs	☐	☐	
Abdomen	☐	☐	
Hernia	☐	☐	
Genitalia (optional)	☐	☐	
Rectum (optional)	☐	☐	
Spine	☐	☐	
Extremities	☐	☐	
Peripheral Vessels	☐	☐	
Reflexes	☐	☐	
Neurologic	☐	☐	

SCREENING

URINALYSIS Sp. Gravity _____ Glucose _____ Protein _____ pH _____ Ketones _____ Blood _____

VISION	LEFT	RIGHT	BOTH	
Far	20/ _____	20/ _____	20/ _____	Corrected: ☐ YES ☐ NO
Near	20/ _____	20/ _____	20/ _____	
Color	Colors of caution: _____ / 3			Color blind: ☐ YES ☐ NO

ROS ☐ Asthma ☐ HTN ☐ Diabetes

PMH

PSH

MEDS

PROVIDER SIGNATURE

DATE

OSHA Respirator Medical Evaluation • Part A

FORM MC-105

TO THE EMPLOYER Answers to questions in Section 1, and question 9 in Section 2 of Part A, do not require a medical examination.**TO THE EMPLOYEE** 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.**PART A • SECTION 1 — MANDATORY FOR EVERY EMPLOYEE SELECTED TO USE A RESPIRATOR**

FIRST NAME	LAST NAME	SSN / EMPLOYEE ID
DATE OF BIRTH	AGE	SEX ☐ Male ☐ Female
HEIGHT (FT / IN)	WEIGHT (LB)	CELL / HOME PHONE
		BEST TIME TO REACH YOU
COMPANY	LOCATION / JOB #	YOUR JOB TITLE

Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ YES ☐ NO

Check the type of respirator you will use (you can check more than one category):

- A. ☐ N, R, or P disposable respirator (filter mask, non-cartridge type only).
B. ☐ Other type (ex...half or full-facepiece type, powered-air purifying, supplied-air, (SCBA) self-contained breathing apparatus).

Have you ever worn a respirator? ☐ YES ☐ NO

If "YES", What type(s): _____

Have you ever failed a respirator examination or pulmonary function test? ☐ YES ☐ NO

If "YES", Why? _____

Have you ever been denied or turned down for the use of a respirator? ☐ YES ☐ NO

If "YES", Why? _____

PART A • SECTION 2 — MANDATORY

Questions 1 through 9 must be answered by every employee who has been selected to use any type of respirator.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐ YES ☐ NO

If "YES", How long have you been smoking? _____ Amount per day? _____

What type of tobacco? (Check all that apply) ☐ Cigarettes ☐ Cigars ☐ Pipe tobacco

If "NO", Are you a former smoker? ☐ YES ☐ NO

How long ago did you quit? _____ How long did you smoke? _____ Amount per day? _____

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

Explain all "yes" answers in the space provided (Include dates and treatment)

- | | | |
|--|--|-------|
| A. Seizures | ☐ 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?

Explain all "yes" answers in the space provided (Include dates and treatment)

- | | | |
|---|--|-------|
| 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've been told about | ☐ YES ☐ NO | _____ |

OSHA Respirator Medical Evaluation • Part A

FORM MC-105

FIRST NAME

LAST NAME

DATE OF BIRTH

TODAY'S DATE

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

Explain all "yes" answers in the space provided (Include dates and treatment)

- | | | |
|---|--|-------|
| 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 you think may be related to lung problems | ☐ YES ☐ NO | _____ |

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

Explain all "yes" answers in the space provided (Include dates and treatment)

- | | | |
|--|--|-------|
| 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've been told about | ☐ YES ☐ NO | _____ |

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

Explain all "yes" answers in the space provided (Include dates and treatment)

- | | | |
|---|--|-------|
| 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 2 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 you think may be related to heart or circulation problems | ☐ YES ☐ NO | _____ |

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

Explain all "yes" answers in the space provided (List medications and dosages)

- | | | |
|-------------------------------|--|-------|
| A. Breathing or lung problems | ☐ YES ☐ NO | _____ |
| B. Heart trouble | ☐ YES ☐ NO | _____ |
| C. Blood pressure | ☐ YES ☐ NO | _____ |
| D. Seizures | ☐ YES ☐ NO | _____ |

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

Explain all "yes" answers in the space provided

☐ Check if you have never used a respirator, then skip to question 9

- | | | |
|--|--|-------|
| 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 to the health care professional who will review your answers on this questionnaire?

☐ YES ☐ NO

OSHA Respirator Medical Evaluation • Questions 10–15

FORM MC-105

FIRST NAME

LAST NAME

DATE OF BIRTH

TODAY'S DATE

MANDATORY for every employee selected to use a full-facepiece respirator or a self-contained breathing apparatus (SCBA).

VOLUNTARY for employees selected to use other types of respirators — answering questions 10–15 is optional.

10. Have you ever lost vision in either eye (temporarily or permanently)? ☐ YES ☐ NO _____

11. Do you currently have any of the following vision problems?

Explain all "yes" answers in the space provided (Include dates and treatment)

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 hearing problems?

Explain all "yes" answers in the space provided (Include dates and treatment)

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?

Explain all "yes" answers in the space provided (Include dates and treatment)

A. Weakness in any part 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 _____

PART B • DISCRETIONARY QUESTIONS

Any of these questions, and others not listed, may be added at the discretion of the reviewing health care professional.

1. In your present job, are you working at high altitudes (over 5,000 ft) or in a place that has lower than normal amounts of oxygen? ☐ YES ☐ NO

If "YES", do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions? ☐ YES ☐ NO

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust) or have you come into skin contact with hazardous chemicals? ☐ YES ☐ NO

If "YES", Name the chemicals if you know them: _____

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

If "YES", Describe these exposures (Include dates and treatment)

A. Asbestos ☐ YES ☐ NO _____

B. Silica (e.g., in sandblasting) ☐ YES ☐ NO _____

C. Tungsten/Cobalt (e.g., grinding or welding this material) ☐ YES ☐ NO _____

D. Beryllium ☐ YES ☐ NO _____

E. Aluminum ☐ YES ☐ NO _____

F. Coal (e.g., mining) ☐ YES ☐ NO _____

G. Iron ☐ YES ☐ NO _____

H. Tin ☐ YES ☐ NO _____

I. Dusty environments ☐ YES ☐ NO _____

J. Any other hazardous exposures ☐ YES ☐ NO _____

4. List any previous occupations: _____

5. List your current and previous hobbies: _____

6. List any second jobs or side businesses you have: _____

OSHA Respirator Medical Evaluation • Part B

FORM MC-105

FIRST NAME

LAST NAME

DATE OF BIRTH

TODAY'S DATE

7. 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

List the chemicals (if known): _____

8. Have you ever worked on a HAZMAT team?☐ YES ☐ NO

If "YES", please list: _____

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason? (Including over-the-counter medications)☐ YES ☐ NO

If "YES", Name the medications (if known): _____

10. Will you be using any of the following items with your respirator(s)?**A.** HEPA Filters☐ YES ☐ NO**B.** Canisters (e.g., gas masks)☐ YES ☐ NO**C.** Cartridges☐ YES ☐ NO**11. How often are you expected to use the respirator(s)?****A.** Escape only (No Rescue)☐ YES ☐ NO**B.** Emergency Rescue only☐ YES ☐ NO**C.** Less than 5 hours per week☐ YES ☐ NO**D.** Less than 2 hours per day☐ YES ☐ NO**E.** 2 to 4 hours per day☐ YES ☐ NO**F.** Over 4 hours per day☐ YES ☐ NO**12. During the period you are using the respirator(s), is your work effort:****A.** Light (less than 200 kcal per hour)☐ YES ☐ NO

If "YES", how long does this period last during the average shift: _____ hours _____ minutes

* Examples of light work effort: sitting while writing, typing, drafting, or performing light assembly work; standing while operating a drill press (1-3 lbs.) or controlling machines.

B. Moderate (200 to 350 kcal per hour)☐ YES ☐ NO

If "YES", how long does this period last during the average shift: _____ hours _____ minutes

* Examples of moderate work effort: sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

C. Heavy (above 350 kcal per hour)☐ YES ☐ NO

If "YES", how long does this period last during the average shift: _____ hours _____ minutes

* Examples of heavy work effort: lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing/equipment (other than the respirator) when you are using your respirator?☐ YES ☐ NO

If "YES", please describe this protective clothing and/or equipment: _____

14. Will you be working under hot conditions? (Temperatures exceeding 77° Fahrenheit)☐ YES ☐ NO**15. Will you be working under humid conditions?**☐ YES ☐ NO**16. Describe the work you will be doing while you are using your respirator(s):****17. Describe any special or hazardous conditions you might encounter when you are using your respirator(s)?**

(e.g., confined spaces, life-threatening gases): _____

18. Provide the following information (if known) for each toxic substance that you will be exposed to when you are using your respirator(s):**A.** 1st toxic substance (name): _____

Estimated max exposure level per shift: _____ Duration of exposure per shift: _____

B. 2nd toxic substance (name): _____

Estimated max exposure level per shift: _____ Duration of exposure per shift: _____

C. 3rd toxic substance (name): _____

Estimated max exposure level per shift: _____ Duration of exposure per shift: _____

D. List any other toxic substances that you will be exposed to while using your respirator: _____**19. Describe any special responsibilities you will have while using your respirator that may affect the safety and well-being of others.**

(e.g., rescue, security): _____

EMPLOYEE SIGNATURE

DATE

Pulmonary Function Testing Report

FORM MC-106

FIRST NAME

LAST NAME

DATE OF BIRTH

TODAY'S DATE

COMPANY

TEST STATUS☐ PFT has been performed — *attach the results printout to this page***RESULTS**

MEASURE	RESULT	PERCENT PREDICTED	NOTES
FVC	_____	_____	
FEV1	_____	_____	

IF TESTING WAS NOT PERFORMED

Please advise whether the employee is able to use respiratory protective equipment in accordance with 29 CFR 1910.134.

☐ YES ☐ NO**PROVIDER INTERPRETATION & NOTES**

PROVIDER SIGNATURE

DATE

Audiogram

FORM MC-107

ALL FIELDS ARE REQUIRED

EMPLOYEE INFORMATION

EMPLOYEE NAME

SSN / EMPLOYEE ID

DATE OF BIRTH

POSITION / JOB

COMPANY

LOCATION

TEST TYPE & NOISE EXPOSURE☐ Baseline (Applicant / New Hire) ☐ AnnualNOISE EXPOSURE LEVEL _____ ☐ N/A — applicant / new hire

When working in a high noise area, do you wear hearing protection?

☐ YES ☐ NO ☐ N/A — applicant, or not currently exposed to high noise**AUDIOMETRIC THRESHOLDS (DB HL)**

DATE OF EXAM • LEFT EAR	500 HZ	1000 HZ	2000 HZ	3000 HZ	4000 HZ	6000 HZ

DATE OF EXAM • RIGHT EAR	500 HZ	1000 HZ	2000 HZ	3000 HZ	4000 HZ	6000 HZ

AUDIOMETER & EXAMINER

MAKE	MODEL	SERIAL #

AUDIOMETER CALIBRATION DATE

TESTER / EXAMINER NAME

**** Calibration date must be within the last year.**

TESTER / EXAMINER SIGNATURE

DATE

Respirator Fit Test Record

FORM MC-108

EMPLOYEE & TEST DATE

NAME OF EMPLOYEE / APPLICANT

TEST DATE

SIGNATURE OF EMPLOYEE BEING TESTED

RESPIRATOR TESTED*Specific make, style and model # of the respirator used for this test.*

MAKE

STYLE

MODEL #

MASK SIZE *(check one)*☐ Small ☐ Medium ☐ Large ☐ One Size Fits All ☐ Regular**TEST METHOD & RESULT**TYPE OF FIT TEST PERFORMED *(check one)*☐ Qualitative (QLFT) ☐ Quantitative (QNFT) Fit factor (QNFT only): _____

RESULT OF FIT TEST — POSITIVE SEAL?

☐ YES — PASS ☐ NO — FAIL**TEST ADMINISTRATOR**

PRINTED NAME OF TEST ADMINISTRATOR

SIGNATURE OF TEST ADMINISTRATOR

DATE

Return to Work / School Release**FORM MC-109**DATE
_____**To Whom It May Concern,**

This letter certifies that _____

was treated in our office on _____.

Due to his/her medical condition, he/she is advised to refrain from:

- ☐ Work
- ☐ School
- ☐ Other _____

He/She is expected to resume his/her activities on _____.

Please contact our office if you have any questions.

Sincerely,

PROVIDER SIGNATURE
_____DATE
