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THE UNIVERSITY OF BRITISH COLUMBIA

Risk Management Services
3287 University Way – Lib 016
Kelowna, BC., Canada, V1V 1V7
Tel: 250-807-8859
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PART 1: RESPIRATORY HAZARD ASSESSMENT FORM – Worker/Supervisor

PART 1 & 2 (back of form) are to be completed by the worker and/or the supervisor and sent to RMS via email, campus mail, or drop off at RMS offices for review.

1.0 Worker Information		
Last Name:	First Name:	Email:
Work Contact Number:	Department:	Job Title:
Supervisor Name:	Supervisor Contact Number:	Supervisor Email:
Have you ever worn a respirator/dust mask for work purposes?		

2.0 Description of Position

Please describe your job in as much detail as possible, and include any information that you feel may be relevant in terms of hazards you encounter in your workday:

3.0 Work Considerations

What Exposures do you expect to encounter in your work?	☐ Chemical Exposure (e.g. solvents, acids, cleaners, mists) ☐ Dust Exposure (e.g. concrete, welding fumes, dry wall) ☐ Animal/biological Exposure (rodent feces, animal cages)

Other PPE used:	☐ Hard hat	☐ Safety Glasses	☐ Goggles	☐ Noise muffs	☐ Hood

4.0 Work Factors Requiring Respirator Use

What duties do you perform that require respirator use:

Frequency of use:	☐ daily	☐ weekly	☐ monthly	☐ yearly	☐ varies	☐ rarely
Exertion level:	☐ light	☐ moderate	☐ heavy	☐ strenuous	☐ all	
Duration of use per shift:	☐ < ¼ hr	☐ > ¼ hr	☐ > 2 hr	☐ variable		
Temperature during use:	☐ < 0° C	☐ 0 to 25°C	☐ > 25°	☐ all temps		

5.0 HSE USE ONLY

Respirator Required?	☐ Yes	☐ No

If Respirator required book appointment for Fit Test. Use Respirator Selection form & Fit Test Form at appointment.

Signature of RMS:	

*Adapted from the University of Calgary, Respiratory Protected Program, accessed May 2011, adapted June 2011

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PART 2: SELF SCREENING QUESTIONNAIRE FOR RESPIRATOR USERS

This information is required to assess any medical conditions that you may have which would preclude the wearing of a respirator. For your health and safety, further medical examination by your physician may be required if this initial assessment determines the need for medical clearance to wear a respirator.

1.0 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 **currently** have or do you experience any of the following conditions which may affect respirator use? **Or any condition not listed here** that may affect respirator use?	☐ **Yes**	☐ **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/ Heat exhaustion
*Vision impairment	Panic attacks	Seizures	Latex allergy or sensitization
Altered facial features	Color blindness	Dentures	Skin conditions
Persistent cough	Reduce sense of taste	Hearing impairment	Prescription medication
Emphysema	Muscle weakness	Dizziness/Fainting	Claustrophobia

b)	Have you had any previous difficulty while using a respirator?	☐ **Yes**	☐ **No**
c)	Do you have any concern about your future ability to wear a respirator?	☐ **Yes**	☐ **No**

A 'YES" response to either a), b), or c) above indicates that further assessment is required by your physician prior to respirator use. NOTE: Do not provide medical information on this form.

Please consult with your supervisor to ensure that your general vaccinations (such as Tetanus) are up to date. (Tetanus vaccine must be updated every 10 years.) Discuss any additional risks and vaccinations with your supervisor and physician based on your work.

The information requested on this form is collected in compliance with the ***Freedom of Information and Protection of Privacy Act*** **(1996)** and the ***Personal Information Protection Act*** **(2004)** and formal retention schedules in conformance with UBC policies and procedures. For further information about the collection, use and disclosure of this information, contact the Associate Director of Campus Security and Risk Management Services at 205-807-9182.

I have answered the questions truthfully, to the best of my ability and knowledge. I agree to report to my department, faculty, and RMS any change in my physical health that might affect my ability to wear a respirator.

Declaration of Respirator Wearer	
Name (Printed):	Department:
Signature:	Date:

* Vision impairment other than what is managed through corrective lenses.

*Adapted from the University of Calgary, Respiratory Protected Program, accessed May 2011, adapted June 2011