UNIVERSITY OF CALGARY

Respirator User Form

Send completed form to confidential fax # 403-282-8603 or email staffwellness@ucalgary.ca for review

Part 1: Respirator Selection Information Form

Section 1.0 to 6.0 to be completed by the worker and/or the supervisor

1.0 WORKER INFORMATION

Last Name:	First Name:	UCID#:	Email:
Phone #:	Work Site Location:	Department:	Job Title:
Supervisor Name:	Supervisor Email:	Supervisor Phone #:	

2.0 HAZARD IDENTIFICATION

Air Contaminant Identification	CAS Registry Number	SDS Reviewed	Quantity and Concentration Used	Can substance be absorbed through or cause irritation to the eyes or skin?
		☐		☐ Yes ☐ No
		☐		☐ Yes ☐ No
		☐		☐ Yes ☐ No
		☐		☐ Yes ☐ No
		☐		☐ Yes ☐ No
		☐		☐ Yes ☐ No
		☐		☐ Yes ☐ No
		☐		☐ Yes ☐ No

3.0 HAZARD ASSESSMENT

Immediately Dangerous to Life and Health (IDLH)? ☐ Yes ☐ No
Oxygen Content: ☐ Below 19.5% ☐ Ambient ☐ Above 21.5%
Toxic Contaminant? ☐ Yes ☐ No
Air Contaminant Type(s)? ☐ Gas / Vapour ☐ Particulate* ☐ Both
*If particulate, is there oil present in the workplace? ☐ "N" – No oil present ☐ "R" – Oil possible ☐ "P" – Oil present

4.0 CONDITIONS REQUIRING RESPIRATOR USE

Activities requiring 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 hrs ☐ Variable
Temperature during use: ☐ < 0° C ☐ 0 - 25° C ☐ > 25° C ☐ All temps

5.0 WORK CONDITIONS

Emergency Escape Needed or Potentially Needed: ☐ Yes ☐ No
Location of safe area relative to hazardous area: ______
Uncontrolled Hostile Environment: ☐ Emergency escape ☐ Fire fighting ☐ Rescue operations ☐ Spill clean up ☐ Confined spaces ☐ Other: ______
Has the work activity been identified on the HACF? ☐ Yes ☐ No ☐ Attached
Has the work activity been identified on the SOP? ☐ Yes ☐ No ☐ Attached
Engineering controls used: ☐ Yes ☐ No Specify: ______
Administrative controls used: ☐ Yes ☐ No Specify: ______
PPE used: ☐ Hard hat ☐ Safety glasses ☐ Goggles ☐ Noise muffs ☐ Hood ☐ Other:

6.0 TYPES OF RESPIRATORS WORN (check all that apply)

☐ Non-powered air purifying (NPAPR)* ☐ Powered air purifying (PAPR)* ☐ Supplied-air pressure demand ☐ SCBA
☐ Supplied-air continuous-flow ☐ Other (specify): ______
Make/Model of respirator(s) currently used:

7.0 ENVIRONMENT, HEALTH & SAFETY REVIEW

Hazard Ratio = Airborne Concentration / OEL =

Minimum Protection Factor Needed:

*Type of Filter / Cartridge Recommended:

Additional Requirements Needed? ☐ Yes ☐ No Explain:

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Part 2: 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.

1.0 WORKER INFORMATION

Last Name:	First Name:	UCID#:	Email:

Phone #:	Work Site Location:	Department:	Job Title:

Supervisor Name:	Supervisor Email:	Supervisor Phone #:

2.0 RESPIRATOR USER HEALTH CONDITION

Check Yes or No box only. Do not specify medical information on this form

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? ☐ Yes ☐ No

Shortness of breath	Breathing difficulties	Chronic bronchitis
Lung disease	Asthma	Dizziness/nausea
Hypertension	Chest pain or exertion	Hearing impairment
Allergies	Emphysema	Reduced sense of taste
Diabetes	Fainting spells	Reduced sense of smell
Panic attacks	Seizures	Back/neck problems
Vision impairment	Colour blindness	Cardiovascular disease
Dentures	Pacemaker	Unusual facial features/skin conditions
Thyroid problems	Heart problems	Prescription medications to control a condition
Neuromuscular disease	Temperature susceptibility	Other condition affecting respirator use
Claustrophobia/fear of heights		

b) Have you had previous difficulty while using a respirator? ☐ Yes ☐ No

c) Do you have any concerns about your future ability to use a respirator safely? ☐ Yes ☐ No

A 'Yes' answer to (a), (b) or (c) indicates further assessment by a health care professional is required prior to respirator use. Please contact Staff Wellness at 403-220-2918 to arrange an appointment for further health assessment.

If respirator protection is to be used in an IDHL atmosphere, further assessment by a health care professional is required and Staff Wellness should be contacted to make arrangements. Powered air respirator (e.g. PAPR, SCBA) would be used in IDHL atmospheres.

I have answered the questions truthfully, to the best of my ability and knowledge. I agree to report to my department/faculty, Staff Wellness and my physician any change in my physical health that might affect my ability to wear a respirator. I consent to allow Staff Wellness to send information regarding my fitness to wear a respirator to my supervisor. Please note: this consent will remain effective unless revoked by me in writing.

SIGNATURE – RESPIRATOR WEARER

Name (printed):	Signature:	Date: