THE UNIVERSITY OF ALABAMA AT BIRMINGHAM
OH&S Occupational Medicine

Follow-Up Respirator Use Form

Date: _____ **Name**: _____ **Blazer ID:** _____

Work Phone: _____ **Work Location**: Building _____ Room _____

Job Title: _____ **Supervisor**: _____

Since your last fit test or respirator clearance evaluation:

1. Have you developed any medical problems or symptoms that may limit your ability to wear a respirator?

   [ ] NO [ ] YES

2. Have you been told by a health care professional, your supervisor, or the respirator program administrator that you should be medically reevaluated?

   [ ] NO [ ] YES

3. Has there been a change in the workplace conditions, work assignments, physical work effort, protective clothing or other changes that has resulted in a substantial increase in the physical burden on you when wearing a respirator or require a different type of respiratory protection?

   [ ] NO [ ] YES

I understand it is my responsibility to report to my supervisor, or respirator program director, any change in status that may affect my ability to safely use a respirator.

Employee Signature: _____ **Date:** _____

If electronically submitted, the form must be sent from the employee's UAB email account to satisfy the signature requirement.

Form submittal:
1. You may submit completed forms electronically to OHSoccmed@uab.edu. **This is preferred**.
2. You may place the completed forms in a *Confidential Envelop* and return it to: UAB OH&S Occupational Medicine CH19, Suite 445-2041
3. You may fax the completed forms to (205) 934-7487. Please be aware that the fax machine is located in the main OH&S office and confidentiality cannot be assured.
4. You may deliver your completed forms to CH19 Suite 412 and place them in the secured lock box at the receptionist desk.

Below is for completion by OH&S Occupational Medicine

[ ] No medical follow up is necessary at this time based on above responses; proceed with qualitative/quantitative fit test.

[ ] Medical evaluation is indicated at this time based on above responses; do not proceed with the qualitative/quantitative fit test.

Reviewer Signature: _____ **Date:** _____

[ ] Instructed, fit tested and passed: ___N-95 ___N-99 ___N-100 ___PAPR ___SCBA ___1/2 Face ___Full Face

Other: _____ Manufacturer/Size: _____

[ ] Instructed, fit tested and passed: ___N-95 ___N-99 ___N-100 ___PAPR ___SCBA ___1/2 Face ___Full Face

Other: _____ Manufacturer/Size: _____

[ ] Could not fit test/did not pass fit test. [ ] Facial Hair

Tester Signature: _____ **Date:** _____

When Fit Testing has been completed, please FAX this form to OH&S Occupational Medicine at 934-7487.

01/02/2018