

UAB HOSPITAL EMPLOYEE Follow-Up N95 Respirator Use Form

UAB Hospital

UAB Highlands

The Kirklin Clinic

Date: _____ Name (first and last): _____

DOB: _____ Blazer ID: _____ Last 4 digits of SSN: _____

UAB E-Mail Address: _____

(if communication is needed, you will be contacted at your UAB e-mail address)

Job Title: _____ Work Phone: _____

Department: _____ 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 N95 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 N95 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: _____

When completed, bring Follow-Up N95 Respirator Use Form with you to be fit-tested.

]UAB Hospital Employee Health North
Address: RWUH Suite 101 (Russell Wing-1st floor, across from HR)
Phone: (205) 996-9270
Fax: (205) 996-9274

The Kirklin Clinic Employee Health
Address: John Whitaker Building Suite 504
Phone: (205) 801-8530
Fax: (205) 801-8430

For use by UAB Hospital N95 Respiratory Protection Program

This Follow-Up N95 Respirator Use Form has been reviewed according to protocol and is deemed acceptable by the UAB Hospital Physician.

- [] No medical follow-up is necessary at this time based on above responses; proceed with the qualitative N95 fit test.
[] Medical evaluation is indicated at this time based on above responses; do not proceed with the qualitative N95 fit test.

Reviewer Signature: _____ Date: _____

- This employee has been trained and has demonstrated donning the N95 respirator.
 Person has been qualitatively N95 fit tested on _____ by _____
Manufacturer: _____ Model: _____ Size: _____ Test Results: Pass Fail
 Unable to perform fit testing on _____ by _____.
 Facial Hair
 A copy of this medical recommendation was provided to the employee.

Referred to Bill Davis for further testing. Type of Fit Testing: _____
Manufacturer: _____ Model: _____ Size: _____ Test Results: Pass Fail

Fit testing completed on _____ by _____
When referral is complete, please FAX this form to Deanette Johnson at (205) 996-9274.