UAB MEDICINE
EMPLOYEE HEALTH SERVICES

Follow Up N95 Respirator Use Form

☐UAB Hospital ☐UAB Highlands ☐The Kirklin Clinic ☐UAHSF

Date: _____ **Name (first and last):** _____

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

Email Address: _____
(If communication is needed, you will be contacted at email address provided)

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 flr, across from HR)
Phone: (205) 996-9270
Fax: (205) 996-9274

For use by UAB Employee Health 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 [ ] Other_____

[ ] Referred to OH&S for further testing (fax: 4-7487).

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 Hospital Employee Health at (205) 996-9274

1/9/19 SC