

### 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-1<sup>st</sup> 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 Nikki Winston at (205) 996-9274.