Montgomery County
Office of Human Resources
Occupational Medical Services

Medical Determination of Readiness for Respirator Fit-Testing Form

Employee Name:______________________ SS#:______________________

Department: ____________ Position:____________________

To the Health Care Provider completing this form, check the appropriate items below:

____ I certify that I have reviewed the 'Medical History Form for Assessing Readiness For Respirator Mask Fitting Form'

After completing the review of the above form, I certify:

___ The above named employee has been medically certified to wear a positive pressure self-contained breathing apparatus pending successful fit testing.

___ The above named employee ***is not cleared*** for wearing a respirator at this time. Further medical evaluation is necessary to make a final determination.

___ The above named employee may wear a negative pressure breathing apparatus with a tight full fit face piece pending successful fit testing.

___ The above named employee is not recommended for ***any*** respirator use.

___ The employee has been provided with a copy of this form.

The 'Medical History Form for Assessing Readiness For Respirator Mask Fitting Form' has been:

___ Filed in the employee's Occupational Medical Services medical record

___ Returned to the employee for his/her personal records

____
Employee Medical Examiner/other Provider Printed Name

____
Provider's Signature

____
Date of Signature

Dept. – White
Employee – Yellow
Employee Medical Record - Pink

Montgomery County Government

Occupational Medical Services

255 Rockville Pike, Suite 125, Rockville, MD 20850

Phone: 240-777-5118 Fax: 240-777-5132

SYMPTOM REVIEW CHECKLIST FOR HISTORY OF POSTIVE PPD

Occupational Medical Services requests that you fill out this brief questionnaire in order to confirm your skin test status. You will be asked to complete this form in lieu of having a PPD test for TB.

Name: ______________________ **DOB:** ______________________

Work Site: ______________________ **Job Title:** ______________________

Work Number: ______________________ **Cell Number:** ______________________

Are you having or have you had:

1.) Cough for more than three (3) weeks? ☐Yes ☐No

2.) Coughing up blood? ☐Yes ☐No

3.) Fever or chills for more than three (3) weeks? ☐Yes ☐No

4.) Night sweats? ☐Yes ☐No

5.) Unexplained weight loss of 10 pounds or more? ☐Yes ☐No

6.) Have you ever been told you have TB? ☐Yes ☐No

If yes, date and type of treatment: ______________________

7.) Have you ever been treated preventively for TB? ☐Yes ☐No

If yes, date and type of treatment: ______________________

Signature of Applicant/ Employee ______________________ **Today's Date:** __________

Nurse Signature: ______________________ **Date of Review:** __________