Office of Human Resources
FIRE & RESCUE OCCUPATIONAL MEDICAL SERVICES
27 Courthouse Square, Suite 180, Rockville, MD 20850 • 240-777-5185

EMPLOYEE MEDICAL HISTORY

EMPLOYEE NAME: _____ DFRS ID NO.: _____

☐ MALE ☐ FEMALE POSITION: _____ DOB: _____

I. MEDICAL HISTORY HEALTH CONDITIONS	NEVER HAD	HAD BUT DO NOT HAVE NOW	NOW HAVE	DO NOT KNOW
CARDIOVASCULAR				
Elevated Blood Pressure				
Episodes of chest pain, tightness, discomfort				
Palpitations or irregular hearbeat				
Swelling of both feet, ankles or legs				
Heart Attack or Angina				
Enlarged Heart				
Heart Bypass surgery, angioplasty or blood vessel surgery				
Stroke				
Heart Murmurs				
Elevated Cholesterol				
Rheumatic Fever				
Other Heart Condition				
RESPIRATORY SYSTEM				
Persistent or severe cough				
Coughing up blood				
Shortness of breath				
Tuberculosis				
Pneumonia				
Asthma				
Emphysema				
Sinus, hay fever, seasonal allergies				
Sleep Apnea				
ENDOCRINE SYSTEM				
Diabetes				
Hypoglycemia (low blood sugar)				
Thyroid condition				
Unexplained Weight Gain				
Unexplained Weight Loss				
GASTROINTESTINAL SYSTEM				
Recurrent indigestion/heartburn				
Jaundice				

I. MEDICAL HISTORY HEALTH CONDITIONS	NEVER HAD	HAD BUT DO NOT HAVE NOW	NOW HAVE	DO NOT KNOW
EYES AND VISION				
Detached retina				
Eye Injury				
Eye Surgery				
Eye Disease / Blindness				
EARS AND HEARING				
Pressure in ears				
Ringing in ears				
Ear injury				
Ear aches				
Ear infections				
Ear drainage				
Hearing loss				
Change in hearing				
PSYCHOLOGICAL OR MOOD				
Persistent or severe difficulty sleeping				
Stress related disorder/Anxiety				
Suicidal/attempted suicide				
Persistent or severe depression/worry				
Excessive use of alcohol/drugs				
MUSCULO-SKELETAL (bones/joints)				
Swollen or painful joints				
Neck or upper back problem				
Low back pain or problem				
Shoulder pain or problem				
Wrist/hand/elbow pain or problem				
Knee pain or problem				
Foot/ankle pain or problem				
Gout				
Osteoporosis				
GENTRO-URINARY				
Breast mass/Cyst				
Testicular Mass				
Enlarged lymph nodes				
OTHER				
Anemia				
Hernia				

_____

EMPLOYEE NAME: _____ DOB: _____

II. FAMILY HISTORY

	MOTHER		FATHER		MATERNAL GRANDMOTHER		MATERNAL GRANDFATHER		PATERNAL GRANDMOTHER		PATERNAL GRANDFATHER		BROTHERS/ SISTERS		NATURAL CHILDREN (BORN LIVE)	
	Died of	*History of*	*Died of*	*History of*	*Died of*	*History of*	*Died of*	*History of*	*Died of*	*History of*	*Died of*	*History of*	*Died of*	*History of*	*Died of*	*History of*
1. Heart Attack or Heart Disease																
2. High Blood Pressure																
3. Stroke																
4. Tuberculosis																
5. Severe Loss of Hearing Before Age 50																
6. Glaucoma																
7. Diabetes																
8. Lvier or Gall Bladder Disease/Condition																
9. Kidney Disease/Condition																
10. Convulsions/Epilepsy																
11. Blood or Lymph Disease/Condition																
12. Cancer																

III. SMOKING HISTORY

1. Do you smoke? ..... ☐ YES ☐ NO
2. Have you smoked in the past? ..... ☐ YES ☐ NO
3. If you now smoke, or smoked in the past, how many years total have you smoked? ..... _____
4. If you now smoke, or have smoked in the past, how many packs per day do/did you smoke on the average?
   ☐ Less than ½ pack ☐ 1 pack ☐ 1½ packs ☐ 2 packs ☐ 2½ packs ☐ 3 packs ☐ 3+ packs

The following questions refer to specific components of the periodic physical examination:

IV. GRADED EXERCISE TEST

1. Do you have any health problems today that may prevent you from walking or jogging on a treadmill? ..... ☐ YES ☐ NO
2. List any prescribed or over the counter medications you have taken in the past 24 hours: _____
   _____
3. How much caffeine (coffee, tea, soft drinks) have you consumed in the past 12 hours? _____
4. Have you exercised regularly in the past 2 months? ..... ☐ YES ☐ NO
   If yes, type of exercise: _____
   Days per week: _____ Minutes per day: _____

V. PULMONARY FUNCTION

1. In the past year, did you work at a "dusty" job? ..... ☐ YES ☐ NO
2. In the past year, have you been exposed to gas or chemical fumes in your work? ..... ☐ YES ☐ NO
   Type: _____ If yes, was exposure: ☐ Mild ☐ Moderate ☐ Severe
   Have you ever been exposed to asbestos at work? ..... ☐ YES ☐ NO
   If yes, please explain: _____
3. Do you wear a SCBA or other type of respirator on the job? ..... ☐ YES ☐ NO
   If yes, how often? _____ What kind? _____
4. Has there been any change in your health status since your previous respiratory fit test? ..... ☐ YES ☐ NO
   If yes, please describe: _____

VI. HEARING

1. Have you recently had a cold? ..... ☐ YES ☐ NO
2. Have you been exposed to loud noise within the past 24 hours? ..... ☐ YES ☐ NO
3. In general, is your workplace loud? ..... ☐ YES ☐ NO
4. Does your worksite provide hearing protection for you? ..... ☐ YES ☐ NO
5. Do you wear hearing protection at work? ..... ☐ YES ☐ NO
6. During the past year have you been exposed to any of the following noises:
   Firearms/guns ..... ☐ YES ☐ NO Motorcycles: ..... ☐ YES ☐ NO Power Tools (chains saws, etc.) ..... ☐ YES ☐ NO
   Power Lawn Equipment ..... ☐ YES ☐ NO Loud Music: ..... ☐ YES ☐ NO Other _____

Montgomery County Government
OCCUPATIONAL MEDICAL SERVICES
GRADED EXERCISE TEST (GXT) INFORMED CONSENT NOTICE

I, _____, understand that as part of my job-related physical examination, I am required by Montgomery County to undergo a Graded Exercise Test. Occupational Medical Services, and such assistants as may be designated, will administer the test. The staff conducting the test is licensed healthcare professionals certified in Advanced Cardiac Life Support. All testing is supervised by a licensed physician, who is present in Occupational Medical Services when testing is conducted, and who is experienced in interpreting test results.

This test is designated to measure my level of fitness. It is also a screening tool to evaluate any current, significant, heart disease and my risk for development of significant heart disease in the future.

I understand that I will walk on a motor driven treadmill. During the performance of physical activity, my electrocardiogram will be monitored and my blood pressure measured and recorded at periodic intervals. Exercise will be increased progressively until I reach the mets (a measurement of how much oxygen your body is consuming) for my position listed below without exceeding 90% of my predicted maximum heart rate based upon my age, I become distressed in any way, or I develop any abnormal response that the testing professional considers significant, whichever of the events occurs first.

Police Officer and Police Officer Candidates – 12 mets
Correction Officer and Correction Officer Applicants – 10.1 mets
Deputy Sheriff and Deputy Sheriff Applicants – 10.1 mets
Firefighter / Rescuer and Firefighter / Rescuer Applicants – 12 mets

I understand that I may terminate the test at any point (when I feel I am unable to proceed) by notifying the testing professional. My rating of "pass" or "fail" on the treadmill test itself is based upon my achieving the required mets without exceeding 90% of my predicted maximum heart rate based upon my age.

Every effort will be made to conduct the test in such a way as to minimize discomfort and risk. I understand, however, that there are potential risks (approximately 2-3 per 10,000 tests) associated with a Graded Exercise Test, just as there are risks associated with any routine medical procedure, including diagnostic tests. These include episodes of transient lightheadedness, fainting, chest discomfort and leg cramps. On very rare occasions, heart attack or sudden death may occur. I further understand that professional personnel furnished with appropriate equipment, including a physician are available. These medical professionals are trained to administer initial emergency care until the Emergency Medical System (EMS) personnel arrive. This notice does not release the County's agents or employees of liability.

I have read and understand the above. I have been given an opportunity to ask questions about the Graded Exercise Test and my questions have all been answered to my satisfaction.

_____ _____

Employee / Applicant Signature Date

Montgomery County Government

Occupational Medical Services

27 Courthouse Square, Suite 180, 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 Quant 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:** _____

FRS N-95 Fit Testing

Test Date: _____

Member's Full Name: _____
Last Name *First Name* *M.I.*

Member FSID: _____

Affiliation:
☐ LFRD ☐ CAREER ☐ HHS ☐ Sheriff ☐ MCPD

Member Battalion:
☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
☐ PSHQ ☐ ECC ☐ FEI

Member Station: FS_____

LFRD:

☐ Career	☐ Silver Spring	☐ Takoma Park	☐ Hillandale
☐ Burtonsville	☐ Bethesda	☐ BCC	☐ Chevy Chase
☐ Cabin John	☐ Glen Echo	☐ Rockville	☐ Gaithersburg
☐ Kensington	☐ WVRS	☐ Laytonsville	☐ Damascus
☐ Upper Mont	☐ Hyattstown	☐ Germantown	☐ Sandy Spring

For Office Use Only

Test Location: OMS/FROMS

Mask Model: ☐ 3M-8210 ☐ Other N-95: _____

Taste Threshold:
☐ 10 ☐ 20 ☐ 30

Outcome:
☐ Pass ☐ Fail

Fit Tester: _____

MONTGOMERY COUNTY GOVERNMENT
OCCUPATIONAL MEDICAL SECTION
PULMONARY FUNCTION QUESTIONNAIRE AND TEST

NAME: _____ EMPLOYEE ID NUMBER _____
JOB TITLE _____ WORK SITE _____

Do you smoke currently cigarettes, cigars or a pipe? ___yes ___no
If yes: How many years? _____ How much? _____ per day.
Have you ever been a smoker in the past? ___yes ___no
If yes: How many years? _____ When did you stop? _____
In the past year; Did you work in a dusty job? ___yes ___no
If yes, was exposure: Mild ____ Moderate ____ Severe ____
Were you exposed to gas or chemical fumes in your work? ___yes ___no
If yes, was exposure: Mild ____ Moderate ____ Severe ____
In the past year: Were you exposed to toxic fumes in your job? ___yes ___no
If yes, was exposure: Mild ____Moderate ____ Severe ____.
Nature of fumes if known: _____
Do you use a SCBA or other type of respirator on the job? ___yes ___no
How often? ___ ___ What Kind? _____
Are you currently taking medications? ___yes ___no
If yes, Name of medication _____ purpose _____
Are you suffering from a cold or allergies today? ___yes ___no
Have you ever had exposure to asbestos on the job? ___yes ___no
Explain: _____

In the past year have you had:

Asthma	yes___ no___
Bronchitis	yes___ no___
Chest Surgery	yes___ no___
Pneumonia	yes___ no___
Hayfever	yes___ no___
Tuberculosis	yes___ no___
Epilepsy	yes___ no___
Rheumatic Fever	yes___ no___
Diabetes	yes___ no___
Cancer	yes___ no___
Kidney Disease	yes___ no___
Bladder Disease	yes___ no___
Jaundice	yes___ no___
Chest Pain	yes___ no___
Other	yes___ no___

FOR OFFICE USE ONLY

Glue Top Section Only

Please comment on any yes answers:

_____

Do you have:?

__ frequent colds	yes___ no___
__ chronic cough	yes___ no___
shortness of breath climbing steps one flight or walking?	yes___ no___

Employee's Signature: _____ Date: _____
Technician Comments: _____

Physician Signature: _____

Interpretation: _____

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
Fire/Rescue Occupational Medical Services
Medical History Form for Assessing Readiness
For Respirator Mask Fitting

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

Can you read (circle one): Yes/No

Note to employer: If the employee indicates he/she cannot read, he/she is to be referred to OMS for assistance in completing the questionnaire.

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Please read: Please complete this questionnaire during your work hours. Be sure to answer all questions as thoroughly as possible. When you have finished, place the form in an envelope marked 'Confidential', seal it, and send it to Occupational Medical Services [OMS]. If the Employee Medical Examiner determines an examination is necessary, you will be notified to schedule an appointment.

Part A Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:_____

2. Your name: _____ Social Security #: _ _ _ - _ _ - _ _ _ _

3. Your age (to nearest year):_____ 4. Sex (circle one): Male/Female

5. Your height: ____ ft. ____ in. 6. Your weight: _____ lbs.

7. Your job title: _____ Dept: _____ Dept. Contact: _____

8. A phone number where you can be reached by OMS: _____

9. The best time to phone you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

11. Check the type of respirator you will use (you can check more than one category):

a. ____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
b. ____ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s):_____

_____

Montgomery County Government
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Medical History Form for Assessing Readiness
For Respirator Mask Fitting

Part A Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month: Yes/No

2. Have you **ever had** any of the following conditions?

a. Seizures (fits)	Yes	No
b. Diabetes (sugar disease)	Yes	No
c. Allergic reactions that interfere with your breathing	Yes	No
d. Claustrophobia (fear of closed-in places)	Yes	No
e. Trouble smelling odors	Yes	No

3. Have you **ever had** any of the following pulmonary or lung problems?

a. Asbestosis	Yes	No
b. Asthma	Yes	No
c. Chronic bronchitis	Yes	No
d. Emphysema	Yes	No
e. Pneumonia	Yes	No
f. Tuberculosis	Yes	No
g. Silicosis	Yes	No
h. Pneumothorax (collapsed lung)	Yes	No
i. Lung cancer	Yes	No
j. Broken ribs	Yes	No
k. Any chest injuries or surgeries	Yes	No
l. Any other lung problem that you've been told about	Yes	No

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath	Yes	No
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	Yes	No
c. Shortness of breath when walking with other people at an ordinary pace on level ground	Yes	No
d. Have to stop for breath when walking at your own pace on level ground	Yes	No
e. Shortness of breath when washing or dressing yourself	Yes	No
f. Shortness of breath that interferes with your job	Yes	No
g. Coughing that produces phlegm (thick sputum)	Yes	No
h. Coughing that wakes you early in the morning	Yes	No
i. Coughing that occurs mostly when you are lying down	Yes	No
j. Coughing up blood in the last month	Yes	No
k. Wheezing	Yes	No
l. Wheezing that interferes with your job	Yes	No
m. Chest pain when you breathe deeply	Yes	No

n. Any other symptoms that you think may be related to lung problems — Yes No

5. Have you **ever had** any of the following cardiovascular or heart problems?

a. Heart attack — Yes No
b. Stroke — Yes No
c. Angina — Yes No
d. Heart failure — Yes No
e. Swelling in your legs or feet (not caused by walking) — Yes No
f. Heart arrhythmia (heart beating irregularly) — Yes No
g. High blood pressure — Yes No
h. Any other heart problem that you've been told about — Yes No

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest — Yes No
b. Pain or tightness in your chest during physical activity — Yes No
c. Pain or tightness in your chest that interferes with your job — Yes No
d. In the past two years, have you noticed your heart skipping or missing a beat — Yes No
e. Heartburn or indigestion that is not related to eating — Yes No
f. Any other symptoms that you think may be related to heart or circulation problems — Yes No

7. Do you **currently** take medication for any of the following problems?

a. Breathing or lung problems — Yes No
b. Heart trouble — Yes No
c. Blood pressure — Yes No
d. Seizures (fits) — Yes No

8. If you've used a respirator, have you **ever had** any of the following problems? (If you've never used a respirator, check the following space and go to question 9:) ___

a. Eye irritation — Yes No
b. Skin allergies or rashes — Yes No
c. Anxiety — Yes No
d. General weakness or fatigue — Yes No
e. Any other problem that interferes with your use of a respirator — Yes No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? — Yes No

Montgomery County Government
Fire/Rescue Occupational Medical Services
Medical History Form for Assessing Readiness
For Respirator Mask Fitting

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you **ever lost** vision in either eye (temporarily or permanently) Yes No

11. Do you **currently** have any of the following vision problems?

a. Wear contact lenses	Yes	No
b. Wear glasses	Yes	No
c. Color blind	Yes	No
e. Any other eye or vision problem	Yes	No

12. Have you **ever had** an injury to your ears, including a broken ear drum? Yes No

13. Do you **currently** have any of the following hearing problems?

a. Difficulty hearing	Yes	No
b. Wear a hearing aid	Yes	No
c. Any other hearing or ear problem	Yes	No

14. Have you **ever had** a back injury? Yes No

15. Do you **currently** have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet	Yes	No
b. Back pain	Yes	No
c. Difficulty fully moving your arms and legs	Yes	No
d. Pain or stiffness when you lean forward or backward at the waist	Yes	No
e. Difficulty fully moving your head up or down	Yes	No
f. Difficulty fully moving your head side to side	Yes	No
g. Difficulty bending at your knees	Yes	No
h. Difficulty squatting to the ground	Yes	No
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs	Yes	No
j. Any other muscle or skeletal problem that interferes with using a respirator	Yes	No

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? Yes No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you're working under these conditions? Yes No

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For Respirator Mask Fitting

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (**e.g.**, gases, fumes, or dust), or have you come into skin contact with hazardous chemicals? Yes No

If "yes," name the chemicals if you know them: _____

_____

_____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below?

a. Asbestos	Yes	No
b. Silica (**e.g.**, in sandblasting)	Yes	No
c. Tungsten/cobalt (**e.g.**, grinding or welding this material)	Yes	No
d. Beryllium	Yes	No
e. Aluminum	Yes	No
f. Coal (for example, mining)	Yes	No
g. Iron	Yes	No
h. Tin	Yes	No
i. Dusty environments	Yes	No
j. Any other hazardous exposures	Yes	No

If "yes," describe these exposures: _____

_____

_____

4. List any second jobs or side businesses you have: _____

_____

5. List your previous occupations: _____

_____

6. List your current and previous hobbies: _____

_____

7. Have you been in the military services? Yes No

If "yes," were you exposed to biological or chemical agents (either in training or combat)? Yes No

8. Have you ever worked on a HAZMAT team? Yes No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)? Yes No

If "yes," name the medications if you know them: _____

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For Respirator Mask Fitting

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters	Yes	No
b. Canisters (for example, gas masks)	Yes	No
c. Cartridges	Yes	No

11. How often are you expected to use the respirator(s)? (Circle "yes" or "no" for all answers that apply to you)

a. Escape only (no rescue)	Yes	No
b. Emergency rescue only	Yes	No
c. Less than 5 hours **per week**	Yes	No
d. Less than 2 hours **per day**	Yes	No
e. 2 to 4 hours per day	Yes	No
f. Over 4 hours per day	Yes	No

12. During the period you are using the respirator(s), is your work effort:

a. **Light** (less than 200 kcal per hour) Yes No

If "yes," how long does this period last during the average shift? ____hrs.___mins.

Examples of a light work effort are **sitting** while writing, typing, drafting, or performing light assembly work; or **standing** while operating a drill press (1-3 lbs.) or controlling machines.

b. **Moderate** (200 to 350 kcal per hour) Yes No

If "yes," how long does this period last during the average shift ____hrs. ___mins.

Examples of moderate work effort are **sitting** while nailing or filing; **driving** a truck or bus in urban traffic; **standing** while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; **walking** on a level surface about 2 mph or down a 5-degree grade about 3 mph; or **pushing** a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. **Heavy** (above 350 kcal per hour) Yes No

If "yes," how long does this period last during the average shift ____hrs. ___mins.

Examples of heavy work are **lifting** a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; **shoveling; standing** while bricklaying or chipping castings; **walking** up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

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13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? Yes No

    If "yes," describe this protective clothing and/or equipment: _____

    _____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F)? Yes No

15. Will you be working under humid conditions? Yes No

16. Describe the work you'll be doing while you're using your respirator(s):

    _____

    _____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

    _____

    _____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

    Name of the first toxic substance: _____
    Estimated maximum exposure level per shift: _____
    Duration of exposure per shift _____
    Name of the second toxic substance: _____
    Estimated maximum exposure level per shift: _____
    Duration of exposure per shift: _____
    Name of the third toxic substance: _____
    Estimated maximum exposure level per shift: _____
    Duration of exposure per shift: _____
    The name of any other toxic substances that you'll be exposed to while using your respirator:

    _____

    _____

    _____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue or security):

I certify that I have read and understood the questions and reviewed my responses. My answers are complete and accurate to the best of my knowledge and belief.

Signature _____ Date _____