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| ***REPLACE WITH YOUR MASTHEAD*** |
| **VFIS logo black JPG** | **SOG Title:** |
| **SOG Number:** |
| **Original Date:** | **Revision Date:** |
| **ABC Fire Department General Operating Guideline** |

**Self-Contained Breathing Apparatus Medical Evaluation**

***This is a sample of a standard operating guideline (SOG) on this topic. You should review the content, modify as appropriate for your organization, have it reviewed by your leadership team and if appropriate your legal counsel. Once adopted, make sure the SOG is communicated to members, implemented and performance monitored for effective implementation.***

**Policy:**

The purpose of this policy is to outline parameters of respiratory protection for the fire and EMS personnel. This policy shall reduce the risk of injury and illness to Fire and EMS personnel while they are working in atmospheres that are immediately dangerous to life and health (IDLH), hazardous, and /or toxic.

**Scope:**

This policy shall be applicable to all personnel operating within the \_\_\_\_\_\_\_\_\_\_\_\_\_\_ fire and emergency medical service system.

**Procedures:**

**Medical Evaluations**

1. All members shall complete an annual OSHA Respirator Medical Evaluation Questionnaire and a medical examination in accordance with OSHA 29 CFR 1910.134.
2. All volunteer members shall complete an annual OSHA Respirator Medical Evaluation Questionnaire in accordance with OSHA 29 CFR 1910.134.
	1. The member's agency shall ensure that each member qualified to wear a respirator completes a questionnaire and forwards it to the department physician annually. This will normally be in conjunction with annual fit testing.
	2. The member's agency shall ensure a member completes the necessary follow up if their initial medical questionnaire review demonstrates the need for additional medical review or examination by the department physician.
	3. Any member not receiving an annual OSHA Medical Evaluation Questionnaire shall be deemed unfit to participate in emergency and/or training activities that may involve IDLH atmospheres.
	4. Any members with a start date prior \_\_\_\_\_\_\_\_\_\_\_ shall be exempt from section 1.
3. The department physician will provide a written recommendation regarding the member's ability to use the respirator (Attachment B). This record shall be maintained according to Table

**OSHA Respirator Medical Evaluation Questionnaire**

**To the employee:**

Can you read (circle one): Yes/No

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.

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Your age (to nearest year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Sex (circle one): Male / Female
5. Your height: \_\_\_\_\_\_\_\_\_\_ft. \_\_\_\_\_\_\_\_\_\_in.
6. Your weight: \_\_\_\_\_\_\_\_\_\_lbs.
7. Blood Pressure (Today): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Pulse (Today): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. Primary Physician Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
12. Primary Physician Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
13. Your job title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
14. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
15. The best time to phone you at this number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
16. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No
17. Check the type of respirator you will use (you can check more than one category):
	1. \_\_\_\_\_\_\_\_\_\_ N, R, or P disposable respirator (filter-mask, non- cartridge type only).
	2. \_\_\_\_\_\_\_\_\_\_ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self- contained breathing apparatus).
18. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s):

**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?

Seizures (fits): Yes/No

Diabetes (sugar disease): Yes/No

Allergic reactions that interfere with your breathing: Yes/No

Claustrophobia (fear of closed-in places): Yes/No

Trouble smelling odors: Yes/No

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

Asbestosis: Yes/No

Asthma: Yes/No

Chronic bronchitis: Yes/No

Emphysema: Yes/No Pneumonia: Yes/No

Tuberculosis: Yes/No Silicosis: Yes/No

Pneumothorax (collapsed lung): Yes/No

Lung cancer: Yes/No

Broken ribs: Yes/No

Any chest injuries or surgeries: Yes/No

Any other lung problem that you've been told about: Yes/No

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

Shortness of breath: Yes/No

Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No

Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No

Have to stop for breath when walking at your own pace on level ground: Yes/No

Shortness of breath when washing or dressing yourself: Yes/No

Shortness of breath that interferes with your job: Yes/No

Coughing that produces phlegm (thick sputum): Yes/No

Coughing that wakes you early in the morning: Yes/No

Coughing that occurs mostly when you are lying down: Yes/No

Coughing up blood in the last month: Yes/No

Wheezing: Yes/No

Wheezing that interferes with your job: Yes/No

Chest pain when you breathe deeply: Yes/No

Any other symptoms that you think may be related to lung problems: Yes/No

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

Heart attack: Yes/No

Stroke: Yes/No Angina: Yes/No

Heart failure: Yes/No

Swelling in your legs or feet (not caused by walking): Yes/No

Heart arrhythmia (heart beating irregularly): Yes/No

High blood pressure: Yes/No

Any other heart problem that you've been told about: Yes/No

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

Frequent pain or tightness in your chest: Yes/No

Pain or tightness in your chest during physical activity: Yes/No

Pain or tightness in your chest that interferes with your job: Yes/No

In the past two years, have you noticed your heart skipping or missing a beat: Yes/No

Heartburn or indigestion that is not related to eating: Yes/ No

Any other symptoms that you think may be related to heart or circulation problems: Yes/No

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

Breathing or lung problems: Yes/No

Heart trouble: Yes/No

Blood pressure: Yes/No

Seizures (fits): Yes/No

1. 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:) Eye irritation: Yes/No

Skin allergies or rashes: Yes/No

Anxiety: Yes/No

General weakness or fatigue: Yes/No

Any other problem that interferes with your use of a respirator: Yes/No

1. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No
2. Have you ever lost vision in either eye (temporarily or permanently): Yes/No
3. Do you currently have any of the following vision problems?

Wear contact lenses: Yes/No

Wear glasses: Yes/No

Color blind: Yes/No

Any other eye or vision problem: Yes/No

1. Have you ever had an injury to your ears, including a broken ear drum: Yes/No
2. Do you currently have any of the following hearing problems? Difficulty hearing: Yes/No

Wear a hearing aid: Yes/No

Any other hearing or ear problem: Yes/No

Have you ever had a back injury: Yes/No

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

Weakness in any of your arms, hands, legs, or feet: Yes/No

Back pain: Yes/No

Difficulty fully moving your arms and legs: Yes/No

Pain or stiffness when you lean forward or backward at the waist: Yes/No

Difficulty fully moving your head up or down: Yes/No

Difficulty fully moving your head side to side: Yes/No

Difficulty bending at your knees: Yes/No

Difficulty squatting to the ground: Yes/No

Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No

Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

**Attachment B**

**OSHA Respirator Questionnaire Medical Recommendation**

Member Name:

[ ]  This person can wear a respirator without restrictions.

[ ]  This person can wear a respirator subject to the following restrictions or limitations:

[ ]  This person cannot use a respirator.

[ ]  A follow-up medical evaluation is required.

I have provided the member named above with a copy of this recommendation.

PLHCP (Name):

Signature:

Date:

***This is a sample guideline furnished to you by VFIS. Your organization should review this guideline and make the necessary modifications to meet your organization’s needs. The intent of this guideline is to assist you in reducing exposure to the risk of injury, harm or damage to personnel, property and the general public. For additional information on this topic, contact your VFIS Risk Control representative.***

**Reference:**

Albemarle County Fire Rescue, Standard Administrative Policy – Respiratory Protection SAP-DEP-056\