Fit Testing Process

STEP ONE

1. **Fill out Resource A completely.** Forms are at the front desk of Greenway and online at www.stillhopes.org/covid-19 . You may print and fill out or fill out electronically and then print.
2. **Fill out name, email, and phone number portion only of Resource B.**
3. Bring forms printed to front desk of Greenway or to the Admin Suite in Greenway.
4. Place completed forms in provided manilla envelope and place in MD/NP labeled mail box. Also says "Fit Testing Forms." If you are turning the form into front desk, please ask them for an envelope for your fit testing forms, place inside, seal, and hand back to the front desk to be placed in the MD/NP box.

STEP TWO

1. Physician reviews the forms and determines if employee can be fit tested.
2. Physician fills out and signs Resource B.
3. Physician puts forms back in manilla envelope and returns to box labeled for Mary Grace Sanders and Katie Wolfe in the admin suite.
4. Fit Testers retrieve envelope from box and contact employee with link to schedule fit testing. Their envelope is filed alphabetically until day of testing.

STEP THREE

1. Employee is given scheduling information via email and text message. Please schedule fit testing as soon as possible.
2. Employee schedules fit testing based on availability shown.

STEP FOUR

1. Show up for fit testing. It is going to be hosted in the Wellness room on River Banks which is across from the activity room.
2. Fit tester completes Resource B and updates on spread sheet. (Line Listing for Fit Testing)
    a. Resource A and B are sent to HR in the manilla folder via interoffice mail.
3. Employee is fit tested and is now able to wear N95 respirator when needed.
4. Please request mask at the front desk at start of shift. They will ask you your name to assure you are given the proper respirator.

Resource A
STILL HOPES

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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.

Employee Name: _____ **Employee ID:** _____

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. (Place completed form in the envelope sealed provided by Still Hopes which will then be provided to the physician.)

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. Your job title: _____
8. A phone number where you can be reached by the healthcare professional who reviews this questionnaire (include the area code). _____
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. ___X____ N, R, or P disposable respirator (filter - mask, non - cartridge type only).
    b. _____ Other type (for example, half- or full-facepiece 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) ? _____

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 or check "yes" or "no").

1. Do you 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. Pneumothorx (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 of 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 <u>currently</u> 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?

Part B (Mandatory)

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

2. List your previous occupations: _____
_____

3. 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 ◯

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

5. 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 ◯

_____ _____

Employee Signature **Date**

Resource B : Qualitative Respiratory Fit Test Medical Approval Form for Still Hopes Episcopal Retirement Community

_____ _____ _____

Employee Name **DOB** **Phone #**

_____

Email Address

MEDICAL Department Use Only

_____ No medical follow up is necessary; PROCEED with fit test.
_____ Medical evaluation is indicated; DO NOT PROCEED with fit test.
_____ Further information is needed prior to fit test.

Licensed Healthcare Professional: _____ Date: _____

TESTING Department Use Only

Testing Agent Used:

- ☐ FT-10 (Saccharin)
- ☐ FT-30 (Bitrex)

Type of Respirator Fitted: Check Respirator and Size

- ☐ **Halyard N-95 Particulate Respirator**
  - ☐ Small (46827)
  - ☐ Regular (46727)
- ☐ **3M N-95 Particulate Respirator**
  - ☐ Healthcare (1870+)
  - ☐ Standard (9205+)
  - ☐ Standard (9210+)
- ☐ **Other Manufacturer**: _____
  - ☐ Size _____

Testing Procedure:

- ☐ normal breathing
- ☐ deep breathing
- ☐ head turn side-to-side
- ☐ head nodding up and down
- ☐ talking
- ☐ repeat normal breathing
- ☐ return demonstration of donning, fit checking, and doffing

Comments:_____
_____

Fit Test Operator: _____ Date: _____

EMPLOYEE Use Only

Due to the possibility of exposure to infectious diseases, I have been fit tested with a personal respirator. I have received training and understand the use and maintenance of this respirator. I agree to abide by all aspects of Still Hopes Episcopal Retirement Community policies concerning the Respiratory Protection Plan, based on OSHA Standard 29 CFR 1910.134. I will direct any questions or concerns regarding respirators to my director or Employee Health. I also understand that it is my responsibility to report to my director any change in health status that may affect my ability to wear a respirator. This record indicates you have completed a qualitative fit test as shown above for the type and size of respirator indicated. Other types will not be used until a fit test has been completed.

Employee's Signature _____ Date: _____