CENTRAL MICHIGAN UNIVERSITY
OFFICE OF LABORATORY AND FIELD SAFETY (OLFS)
MEDICAL EXAMINATION REQUEST

Date

Employee Name____

Employee No.____

Department____

Job Classification____

The above named employee of Central Michigan University has been assigned to work requiring the use of a respirator. It is requested the employee be given an initial/annual medical examination which shall include the following:

☐ 1. A complete physical examination of all systems with emphasis on the respiratory system, the cardiovascular system and digestive tract.

☐ 2. A chest roentgenogram (posterior - anterior 14 x 17 inches)

☐ 3. Pulmonary function tests to include forced vital capacity and forced expiratory volume at 1 second.

☐ 4. Any additional tests deemed appropriate by the examining physician.

The following information should be taken into consideration when evaluating the employee's physical ability to function normally wearing a respirator.

1. The employee's duties related to the anticipated exposure are:

____

____

2. The employee's anticipated exposure level is:

____

____

3. Type of respirator to be used:

____

____

____

Name of BSL-3 Facility Director   Date

Work Ability Report for BSL-3 Facilities

Employee Instructions: Please fill in your full name, CMU ID and phone number and submit with your BSL-3 Questionnaire by fax to (989) 772-4084. Copies of this clearance form will be provided to the Facility Director.

________________________________ ____________ _____________
Employee Name (please print) CMU ID Phone #

For COMP Office Use Only:

Based on the BSL-3 Medical Questionnaire reviewed by McLaren Central Michigan-Occupational Medicine Program (COMP), the above employee is:

- ☐ **Cleared for Work in the BSL-3 Facility (PPE: Back-closing laboratory gown, double-gloves, shoe covers and Powered Air Purifying Respirator)**
- ☐ **Not Cleared for Work in the BSL-3 Facility**
- ☐ **Cleared for Work in the BSL-3 Facility with Restrictions**
- ☐ **Determination Pending further Information**

Comments on Restrictions:

____

____

____________________________ ____________________________
Provider’s Signature Date Signed

Fax this form to COMP at (989) 772-4084

Purpose The purpose of this form is to obtain information about your personal health and work exposure. This information will be used by the McLaren Central Michigan-Occupational Medicine Program (COMP) to make an accurate assessment of your ability to safely work with biological and chemical agents in the BSL-3 laboratory. COMP will evaluate the information on this form and document for you and your supervisor any work restrictions or protective measures to be followed. If restrictions and/or protective measures are required, it is the University's expectation that you will comply.
Directions and Privacy Statement Please complete the full questionnaire and fax it to (989) 772-4084. If faxing from a machine on campus, please dial 9-1-989-772-4084. If you have concerns about privacy and prefer to deliver the completed questionnaire directly to the doctor, you should take it to: Central Occupational Medicine Program Office (COMP) at McLaren-Central Michigan, 1523 S. Mission St., Mt. Pleasant, Michigan.

Regardless of the method of delivery, the information you provide is fully protected by HIPAA. The only data that the University receives from COMP is a form that indicates whether or not you are able to work in a BSL-3 laboratory, and if you require special protection.

PARTICIPANT INFORMATION

Participation in the Occupational Health and Safety (OHS) program is required for all individuals desiring access to the BSL3 facility. The entire process must be completed prior to initiation of work in the facility.

To complete the process, each participant must:

1. Complete the attached medical history questionnaire.
2. Have the BSL-3 Facility Director complete the Medical Examination Request form (located within this document).
3. Complete the OSHA Respirator Medical Evaluation Questionnaire (located at the end of this document).
4. Submit the three forms to COMP using the address or FAX number provided.
5. Schedule an appointment
6. After completing all appointments with COMP, follow directions received from COMP to satisfy any work related restrictions.
7. Schedule PAPR training with OLFS
8. Once you have received clearance from COMP and OLFS and have received your respirator and filters you will have completed the process.

MEDICAL HISTORY

1. **Do you have any of the following conditions?**

Yes	No		Yes	No	
☐	☐	Shortness of breath, difficulty breathing	☐	☐	Tuberculosis
☐	☐	Chronic respiratory condition, asthma	☐	☐	Kidney or liver disease
☐	☐	Persistent cough (for >3 weeks)	☐	☐	Diabetes
☐	☐	Bringing up sputum every day (for >3 weeks)	☐	☐	Chronic infectious disease
☐	☐	Coughing up blood	☐	☐	Skin conditions (e.g., eczema, psoriasis, dermatitis)
☐	☐	Unexplained weight loss (8 lbs or more)	☐	☐	Dizziness, fainting spells, seizures, epilepsy
☐	☐	Unexplained fever	☐	☐	Valvular heart disease
☐	☐	Night sweats	☐	☐	Heart disease or condition
☐	☐	Fatigue or run down feeling (for >3 weeks)	☐	☐	History of spleen problems or absence of spleen
☐	☐	Chest pain			
☐	☐	Immune system deficiencies or other limitation to your ability to fight off disease or infection (for example: cancer, lupus, organ transplant, HIV infection)			
☐	☐	Any other health conditions that you think could be adversely affected by working in a BSL3 facility?			
☐	☐	Any known allergies (chemicals, latex, animals, food, environmental)?			

If yes, please explain:

____

____

2. **Please list all hospitalizations, operations, surgeries and broken bones and the date they occurred:**

____

____

3. **Other than the conditions listed above, are you being treated for any ongoing health problems?** ☐ Yes ☐ No If yes, please explain:

____

____

4. **Do you have any reason to believe that you cannot work safely in an isolated environment?** ☐ Yes ☐ No If yes, please explain:

____

____

5. **Do you have any medical condition for which you feel you should be seen by the Occupational Health Physician?** ☐ Yes ☐ No If yes, please explain:

____

____

6. **Are you taking any of the following medication (Humira, Enbrel, Xeljanz, Orencia, Plaquenil, Remicade, Methotrexate, Prednisone, and others**)?
☐ Yes ☐ No If yes, please list:

____

____

7. **Are you being treated with any cancer treatment drugs?** ☐ Yes ☐ No
If yes, please list:

____

____

8. **Do you have an exposed medical device (e.g., insulin pump) that cannot be removed or decontaminated with immersion it if were to be contaminated with a biological agent?**

   a. **If yes, can you work without using this device?** ☐ Yes ☐ No ☐ Not sure
   b. **If yes, in the event of contamination, is a backup devices available for use?** ☐ Yes ☐ No ☐ Not sure

NOTE: QUESTIONS 9-11 ARE FOR FEMALES ONLY

9. **Are you pregnant or planning to become pregnant within the next 12 months?** ☐ Yes ☐ No

9a. If yes, are you potentially at risk for exposure to any of the following (check all that apply) *Note: It is not possible to list all exposures that may affect pregnancy here.*

- ☐ Toxoplasma gondii (Toxoplasmosis)
- ☐ Brucella bacteria (Brucellosis)
- ☐ Lymphocytic choriomenigitis virus (LCMV)
- ☐ Rubella virus
- ☐ Anesthetic gases
- ☐ Ionizing radiation
- ☐ Listeria bacteria
- ☐ Cytomegalovirus (CMV)
- ☐ Hepatitis B virus
- ☐ Human immunodeficiency virus (HIV)
- ☐ Varicella-zoster virus (chicken pox)
- ☐ Herpes simples virus I and/or II
- ☐ Venzuelan equine encephalitis virus
- ☐ Q fever
- ☐ Wild animals (not screened for possible infections)
- ☐ Cancer treatment drugs
- ☐ Human parvovirus B19
- ☐ Campylobacter bacteria

10. **Are you breastfeeding?** ☐ Yes ☐ No

11. **Would you like to be contacted by an occupational health professional regarding pregnancy concerns?** ☐ Yes ☐ No

12. **Do you have any adverse effects to antibiotics?** ☐ Yes ☐ No
    If yes, please list symptoms (i.e. itchiness, vomiting, etc.):

    ____

    ____

13. **Immunization History**

Yes	No	
☐	☐	**Have you ever received Hepatitis B vaccination? If yes, list dates:**
☐	☐	**Have you ever had a positive TB screening? If yes, list dates:**
☐	☐	**Have you ever received a BCG vaccination? If yes, list dates:**
☐	☐	**Have you had a TB skin test in the past 2 years?** **If yes, list date(s): Result: ___Neg ___Pos**
☐	☐	**Have you ever had a Quantiferon TB screening? Result: ___Neg ___Pos**

14. **Were you born or have you traveled outside the U.S.?** ☐ Yes ☐ No

15. **Have you had close contact with someone who has Tuberculosis (TB)?**
    ☐ Yes ☐ No

Appendix C
OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

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.

To the employee:
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.	Your job title:		
8.	A phone number where you can be reached by the health care 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.		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 "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:	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:	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
Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece 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
	d.	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
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:		

Appendix C
OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

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		
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	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.).		
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):			

Appendix C
OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

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, security):	

Appendix D
Information for Employees Using Respirators When Not Required Under the Standard (Mandatory)

Respirators are an effective method of protection against designated hazards when properly selected and worn. Respirator use is encouraged, even when exposures are below the exposure limit, to provide an additional level of comfort and protection for workers. However, if a respirator is used improperly or not kept clean, the respirator itself can become a hazard to the worker. Sometimes, workers may wear respirators to avoid exposures to hazards, even if the amount of hazardous substance does not exceed the limits set by OSHA standards. If your employer provides respirators for your voluntary use, or if you provide your own respirator, you need to take certain precautions to be sure that the respirator itself does not present a hazard.

You should do the following:

1. Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirators limitations.
2. Choose respirators certified for use to protect against the contaminant of concern. NIOSH, the National Institute for Occupational Safety and Health of the U.S. Department of Health and Human Services, certifies respirators. A label or statement of certification should appear on the respirator or respirator packaging. It will tell you what the respirator is designed for and how much it will protect you.
3. Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designed to protect against. For example, a respirator designed to filter dust particles will not protect you against gases, vapors, or very small solid particles of fumes or smoke.
4. Keep track of your respirator so that you do not mistakenly use someone else's respirator.

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998]