Bassett Healthcare Network
New York Center for Agricultural
Medicine and Health

Dear Fit Test Participant:

The New York Center for Agricultural Medicine and Health (NYCAMH) is pleased to provide respiratory fit testing at agricultural events and trade shows to help customers choose the proper respirator for their needs. A fit test ensures the respirator fits the wearer properly. Before the fit test, we must make sure you're healthy enough to wear a respirator, as there is an increased workload of physical exertion when the mask is on.

In order to make sure you are healthy enough to wear a respirator, we ask you to fill out the OSHA health screening questionnaire. Please fill it out carefully and completely.

The fit test technician will review your paperwork before beginning the fit test. The technician will then obtain blood pressure and peak flow measurements. Under most circumstances, you'll be fit test for your mask. Sometimes, we recommend that you follow up with a medical professional, to ensure your body can handle the increased work load when wearing a mask. Rarely, there are times when we cannot perform the test at all, and you should follow up with a medical professional in order to be cleared for respirator use.

To ensure a proper respirator fit, NYCAMH staff may have you try several types and/or sizes of mask. Fit testing is specific to the brand, model, and size of respirator. If you will be using multiple respirators, you'll need to be fit test for each respirator model.

You **must be clean shaven** to achieve a proper seal between the respirator and skin surface. If there is any hair growth, including stubble, beard, mustache, or sideburns, you will be required to shave prior to being fit test.

Fit tests should be conducted on a yearly basis, as slight bodily changes can affect the way your mask fits. **Unless it fits properly, it is not offering you adequate protection from respiratory hazards.** It is important to us that you be protected from any respiratory hazards. If you have any questions, please call us at 607-547-6023 or 800-343-7527.

Sincerely,

John J. May, MD
Medical Director
The New York Center for Agricultural Medicine and Health
Bassett Healthcare Network
Cooperstown, NY
607-547-6023

HEALTH QUESTIONNAIRE REQUIRED BY OSHA

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

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. Name: 2. Today's date

3. Age (to nearest year): 4. Sex (circle one): Male Female

5. Height: _____ft._____in. 6. Weight: _____lbs.

7a. What is your "day job"? farmworker farm owner farm supervisor other:

b. Number of years on this job: _____

c. Type of farm you work on: Vegetable Fruit Dairy Crop Livestock

d. Do you ever wear a respirator when you work? | YES | NO

e. What type do you wear/use? A) N, R, P disposable respirator (filter mask, non cartridge type)
B) Other type (half or full face piece, powered air purifying, supplied air) C) tractor with charcoal filtered cab

f. Where do you keep your respirator?

g. How do you fit test your respirator (s)? seal check other:

h. Have you ever been professionally fit tested? | YES | NO

i. Have you ever been medically cleared (or your doctor is aware you wear a respirator) to wear a respirator? | YES | NO

j. Do you mix or apply pesticides on the farm? | YES | NO

If YES:

k. What type of pesticides do you apply? Class I (poison) Class II (warning) Class 3 (caution) Class IV(non-toxic)

l. List products if class is not known:

8. Please list your past jobs below:

Dates	Job Title & Description	Protective Equipment Used At Job

Have you ever worked at a job or hobby in which you came in contact with any of the following by breathing, touching, or ingesting (swallowing)? If Yes, please check the box beside the name.

- ☐ Acids
- ☐ Airborne Pathogens
- ☐ Alcohols (industrial)
- ☐ Alkalies
- ☐ Ammonia
- ☐ Arsenic
- ☐ Asbestos
- ☐ Benzene
- ☐ Beryllium
- ☐ Bloodborne Pathogens
- ☐ Cadmium
- ☐ Carbon tetrachloride
- ☐ Chlorinated naphthalenes
- ☐ Chloroform
- ☐ Chloroprene
- ☐ Chromates
- ☐ Coal dust
- ☐ Dichlorobenzene
- ☐ Ethylene dibromide
- ☐ Ethylene dichloride
- ☐ Fiberglass
- ☐ Halothane
- ☐ Isocyanates
- ☐ Ketones
- ☐ Lead
- ☐ Manganese
- ☐ Mercury
- ☐ Methylene chloride
- ☐ Nickel
- ☐ Organic Dust
- ☐ PPBs
- ☐ PCBs
- ☐ Perchloroethylene
- ☐ Pesticides
- ☐ Phenol
- ☐ Phosgene
- ☐ Radiation
- ☐ Rock dust
- ☐ Silica powder
- ☐ Silo Gas
- ☐ Solvents
- ☐ Styrene
- ☐ Talc
- ☐ Toluene
- ☐ TDI or MDI
- ☐ Trichloroethylene
- ☐ Trinitrotoluene
- ☐ Vinyl chloride
- ☐ Welding fumes
- ☐ X-rays
- ☐ Loud noises
- ☐ Other (specify): _____
- ☐ Typical fire exposures including: fumes, particulate aldehydes, carbon monoxide, carbon dioxide, nitrogen dioxide, hydrogen chloride, hydrogen cyanide acrolein, vol. organic compounds

9. A phone number where you can be reached by the health care professional who reviews this questionnaire (including the Area Code):

10. The best time to phone you at this number:

Part A. Section 2. (Mandatory) Explain yes answers in comment section, page 4

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. Asbestos:	YES	NO	g. Silicosis:	YES	NO
	b. Asthma:	YES	NO	h. Pneumothorax (collapsed lung):	YES	NO
	c. Chronic bronchitis:	YES	NO	i. Lung cancer:	YES	NO
	d. Emphysema:	YES	NO	j. Broken ribs:	YES	NO
	e. Pneumonia:	YES	NO	k. Any chest injuries or surgeries:	YES	NO
	f. Tuberculosis:	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 up 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

Part A. Section 2. (Mandatory) (continued) Explain yes answers in comment section, page 4

5.	Have you *ever had* any of the following cardiovascular or heart problems?		
	a. Heart attack: If Yes, when?	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 box 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

BLOOD PRESSURE: Left: _____/_____ **Right:** _____/_____ _____/_____

PEAK FLOW: _____ _____ _____

FIT: _____ _____ **FAIL:** _____ _____

COMMENTS SECTION: