

**University of Massachusetts Medical School Respirator
Fitness Determination**

Name: _____

Graduating Class: _____ Date of Birth ____/____/____

Questionnaire to determine fitness to wear a NIOSH approved respirator. Please check each item **YES** or **NO**. If you check **YES**, please provide an explanation. All questions must be answered.

1. Have you worn a respirator before? ____ No ____ Yes
(what type/for what purpose?) _____
2. Have you had problems wearing a respirator? ____ No ____ Yes Explain _____
3. Do you have claustrophobia or anxiety problems that would make wearing a mask difficult for you? ____ No ____ Yes
4. Do you have a beard or mustache? ____ No ____ Yes Explain _____
5. Do you have problems with your sense of smell? ____ No ____ Yes Explain _____
6. Do you have skin allergies? Other allergies? ____ No ____ Yes Explain _____
7. Do have any heart problems? (Angina, heart failure)? ____ No ____ Yes Are you symptomatic...edema, shortness of breath?. _____
8. Do you have any lung disease (chronic cough, emphysema, asthma, infections, bronchitis)? ____ No ____ Yes
Are you symptomatic? ____ Are you well controlled on medication? _____
9. Do you smoke? ____ No ____ Yes How many packs per day? ____ How many years? ____
Are you symptomatic with respiratory problems? _____
10. Do you have seizures? ____ No ____ Yes Are you well controlled on medication? _____
11. What prescription medications are you taking?

Student Signature: _____ Date: _____

Return the completed form through the Peoplesoft Portal if you are an incoming student. This form only needs to be completed once unless you have a change in facial structure or medical condition. Fit testing is required annually for students in patient facing programs.

Student Health Services Use Only:

_____ Approved for PAPR

_____ Approved for tuberculosis respirator N-95 Mask

_____ Awaiting further data, on medical hold

_____ Not approved for respirator use

Revised 10/2008

Date: _____ Ext. _____

Attachment to 1st e-mail