FastResponse ON-SITE TESTING
Premier Mobile Occupational Health Services

TRAVEL SLIP

○ New Hire
○ Annual

LAST NAME: | FIRST NAME: | COMPANY:

COUNTY/LOCATION: | POSITION: | LAST 4 SSN:

EMAIL ADDRESS: | DATE:

Do Not Write Below This Line

EVALUATION

- **Examination** ☐ D.O.T. Expiration Date: ☐ Other: _____
- **Drug Test**
- **Pulmonary Function Test**
- **OSHA Questionnaire** ☐ Initial ☐ Annual
- **Physical Agility Test**

FIT TESTING

	One	S	M	M/L	L	XL
N95 ☐ 3M 1870 ☐ Moldex ☐ Qualitative	☐	☐	☐	☐	☐	☐
P100 ☐ Sperian ☐ Moldex ☐ 3M 8293 ☐ Gateway TruAir Ultra	☐	☐	☐	☐	☐	☐
MSA Millennium Full Face	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐

LAB

	Submitted dates		Submitted dates		Submitted dates
Tb Testing ☐ Skin Test		☐ Quantiferon			
Blood Titers ☐ Hepatitis B		☐ MMR		☐ Varicella	
Vaccines ☐ Tdap Vaccine		☐ Hepatitais B		☐ Influenza	
Other:					

MISC.

Travel

☐ Scanned
☐ Email Results
☐ Update Spreadsheet
☐ Fee Slip to DB

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ANNUAL RESPIRATOR MEDICAL EVALUATION

Respiratory Protection

NAME: _____ LAST 4 SSN: _____

COMPANY: _____ DIVISION: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____ PHONE: _____

1) Have you developed any medical problems or symptoms that may limit your abitiy to us a respirator within the last year?

◯ NO ◯ YES (If yes, please describe the symptoms or problems)

2) Have you been treated for a heart or lung condition or any other condition in the last year? (ie. heart attack, pneumonia, bronchitis or asthma)

◯ NO ◯ YES (If yes, please describe the condition)

3) Are you currently taking any medications?

◯ NO ◯ YES (If yes, for how long and what purpose?)

4) Has there been a change in workplace conditions that has resulted in a substantial increase in the physical burden on you since your last examination?

◯ NO ◯ YES (If yes, please describe the condition)

5) Do you currently smoke? ◯ NO ◯ YES Have you ever smoked? ◯ NO ◯ YES

If yes, for how long? _____ When did you stop? _____

6) What type of work will you be doing while wearing the respirator ◯ EMS ◯ OTHER

What level of work will you be performing while wearing the respirator **Light Moderate Heavy**

How long will you be wearing the respirator? ◯ > 8 hours ◯ < 8 hours ◯ Episodic

7) What type of respirator do you currently wear or have the potential to wear for you job?

◯ N95 ◯ N100 ◯ P100 ◯ FULL FACE ◯ SCBA

8) How long have you been working in this current job classification? _____

Have you had any complications wearing your respirator this past year? ◯ NO ◯ YES

SIGNATURE OF WORKER: _____ DATE: _____

SIGNATURE OF HEALTHCARE PROVIDER: _____ DATE: _____

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PROTECTIVE TRAINING & FIT TEST REPORT

○ New Hire
○ Annual

EMPLOYEE NAME: _____ LAST 4 OF SSN: _____

EMPLOYER: _____ JOB DESCRIPTION: _____

FIT TESTER AND TRAINER: Fast Response Onsite Testing

Employee acknowledgement of familiarity with user instructions and certain limitations

I have read and understood the user instructions of the respirator, and will follow said user instructions every time I use the respirator. I acknowledge that the respirator protective device will not provide adequate protection when used under conditions other than specified or when user instructions are not followed.

EMPLOYEE SIGNATURE: _____ DATE: _____

TRAINING: Proper use, indications, contraindications, fit checks, don/doff training, care and cleaning of the following respirators were undertaken:

○ N95 ○ N100 ○ P100 ○ HALF FACE ○ FULL FACE ○ SCBA ○ PAPR

FIT TEST: Conditions which may affect respirator fit (completed by conductor)

○ Clean Shaven ○ Moustache/Goatee ○ 1-2 day facial hair growth
○ Glasses ○ Other: _____

Fit Checks:	Pass	Fail
Negative Pressure		
Positive Pressure		
Fit Testing: (Qualitative)		
○ Bitrex Solution ○ Sweet Solution		
Fit Testing: (Quantitative) *Portocount report attached		

	Mask Brand	Mask Type	Mask Size					
			①	S	M	M/L	L	XL
	3M 1870	N95						
	Moldex	N95						
	Moldex	P100						
	Sperian	P100						
	3M 8293	P100						

FIT TEST RESULT:

The fit test procedure was conducted in fulfillment of OSHA's fit testing requirement of employees wearing mask respirators (Code of Federal Regulations 20 CFR 1910.134 (e) (5) and in accordance with American National Standard Institute practices for respirator protection, ANSI Z88.2-1922). Training was also completed as prescribed under 29CFR 1910.134 and Cal OSHA Title 8-5144

Employee Acknowledgement of Test Results:

EMPLOYEE SIGNATURE: _____ DATE: _____

TRAINER/TESTER SIGNATURE: _____ DATE: _____

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RESPIRATORY CLEARANCE

○ New Hire
○ Annual

NAME: _____ DATE: _____

LAST 4 OF SSN: _____ COMPANY: _____

The above employee has been examined and the results of the medical tests indicate the following. Based on the health status of the employee shown above, and on the criteria set by Cal OSHA, this employee is approved for the use of the following respirator(s) for the time frame noted under the clearance conditions stated on the Respirator Usafe Form signed by the safety director of the company.

	N95 FILTER SYSTEM (NON-POWERED)
	N100 FILTER SYSTEM (NON-POWERED)
	P100 FILTER SYSTEM (NON-POWERED)
	AIR-PURIFING FULL-FACE (NON-POWERED)
	AIR-PURIFING (POWERED)
	AIR-LINE RESPIRATOR
	SCBA (FULL FACE)
	FILTERING FACE-PIECE (DUST MASK)
	SURVEILLANCE TESTING ONLY

CFR 29 1910.134 / Cal OSHA Title 8, 5144

◯ **CATEGORY 1: No restrictions on respirator use - No follow up needed**
(Based on this targeted examination - BP check, PFT, OSHA medical evaluation questionnaire and interview) - No additional evaluation is required unless significant change in health of wearer

◯ **CATEGORY 2: No restrictions on respirator use after PFT evaluation**
Annual recheck is needed to monitor respiratory health.
(Based on this targeted examination - BP check, PFT, OSHA medical evaluation questionnaire and interview) - No additional evaluation is required.

◯ **CATEGORY 3: Temporary Respirator Clearance** - on condition that medical follow up with physician has occured within 30 days of the date of this letter
(Based on this targeted examination - BP check, PFT, OSHA medical evaluation questionnaire and interview) - No additional evaluation is required.

◯ **CATEGORY 4: No respirator use permitted**. Requires additional medical evaluation or treatment

◯ **SURVEILLANCE testing only**

◯ **PATIENT REFUSED MEDICAL EVALUATION**

Examining Physician or Licensed Healthcare Professional:

_____ DATE: _____