Appendix C

# Office of Attorney General Medical Forms

#### SUBJECT: **REQUIRED MEDICAL EXAMINATIONS** PA OAG, CRIMINAL LAW DIVISION SPECIAL OPERATIONS GROUP

Dear Doctor:

The purpose of this medical examination is to obtain a medical clearance for the execution of high risk arrest and search warrants, surveillance, and other assignments as a Special Operations Group member. In addition to traditional law enforcement activities, the examinee will be required to use personal protective equipment for protection from chemical, gas, and fire exposure.

The personal protective equipment, work place, and environmental factors of concern are described below. Suggested guidelines for annual medical evaluation have been provided to your examining facility.

Protective Equipment - Will use goggles for eye protection, a full Nomex face mask, Nomex suit, Kevlar helmet, 100 lb, Level III protective vest and carry additional ammunition and equipment. May also be required to wear CN/CS gas mask (military issue), as well as, equipment for clandestine laboratory entry.

Type of Work - Includes pursuit, confrontation, control and arrest of suspects, which may involve strenuous physical activity; includes moderate to excessive exertion while wearing personal protective equipment with increased work of breathing, cardiovascular stress and heat load; includes responsibility for safety of others and responsiveness in rescue and emergency situations; includes a guarterly physical fitness test that consists of a 1.5 miles run, a 6 foot wall climb, a body transport, an agility run, and sit-ups; this will test the strength/short burst of energy output, ability to maneuver job related obstacles with minimal risk of injury (flexibility and coordination), ability to sustain required activities for extended periods of time (stamina and long term energy output), and overall physical conditioning. Also includes enormous hours of shooting firearms and distraction devices in an outdoor/indoor environment.

Work Setting - Work in uncontrolled, poorly ventilated makeshift laboratories with unidentified chemical processes in progress. Potential for fire, explosion, and chemical spills are likely. Potential for exposure to organic solvents, inorganic acids, and alkalis, cyanides, other drug precursors, unknown chemicals, reactants and by-products of chemical reactions to include gases, and controlled substances in solution or powdered form. Potential for contact with violent and armed suspects, as well as, subjects that have been exposed to contagious and transmittable diseases. Includes work outdoors and indoors in extremes of seasonal environmental temperatures and humidity. Prior acclimatization of hot environments is unlikely. Also includes climbing 16 foot ladders and unduly large series of steps in interior of buildings.

If you find the individual cleared for performing the duties described above, and able to wear respiratory personal protective equipment in accordance with 29 CFR 1910.134, please sign and date the certification below and forward it with the results of your examination and related health screening reports to the Office of Attorney General.

#### MEDICAL CERTIFICATION

I have examined	on	and find the individual to be
medically able to perform the duties described above or others.	without unusual medical	risk or harm to the individual

Physician's Signature: \_\_\_\_\_ Date:

Physician's Printed Name:

## SUBJECT: REQUIRED MEDICAL EXAMINATIONS PA OAG, CRIMINAL LAW DIVISION (ENVIRONMENTAL CRIMES SECTION, CLANDESTINE LABORATORY UNIT)

Dear Doctor:

The purpose of this medical examination is to obtain a medical clearance for the below-listed individual to perform his/her duties as an Agent with the Pennsylvania Office of Attorney General, Criminal Law Division. In addition to traditional law enforcement activities, the examinee will be required to use personal protective equipment for protection from potential chemical and/or hazardous material exposure, including the evaluation of illegal drug-manufacturing laboratories.

The personal protective equipment, work place and environmental factors of concern are described below. Suggested guidelines for the annual medical evaluation have been provided to your examining facility.

<u>Protective Equipment</u>: Employee will use a twin cartridge full face mask, air purifying MSA respirator, (Level C), which weighs approximately 3 pounds, and/or a MSA (pressure demand, open circuit) self-contained breathing apparatus, (Level B), which weighs approximately 25 pounds with a full 30-minute fully-wound composite II cylinder, and will use neoprene boots, chemically resistant gloves and a chemically resistant suit of Tyvex or Saranex.

The total number of times that either Level C or Level B protection is worn during the year varies, but an average would be between three (3) to five (5) times. The average length of time used for each level also varies, but normally the protection would be worn about 30 minutes per occurrence. The expected physical work effort required to do the job in the various levels of protection ranges from walking to using shovels to move ground. Temperature extremes can vary from near zero to the mid-90 degrees. Humidity, at times, can reach near 100%.

<u>Type of Work</u>: Includes pursuit, confrontation, control and arrest of suspects which may involve strenuous physical activity; includes light to moderate to possibly heavy exertion while wearing the personal protective equipment described above which may increase breathing, cardiovascular stress and heat load; includes responsibility for the safety of others and responsiveness in rescue and emergency situations.

<u>Work Setting</u>: Work can be in uncontrolled, poorly ventilated makeshift facilities/areas with unidentified chemical processes in progress. Potential for fire, explosion and chemical spills are likely. The potential exists for, but is not limited to, exposure to organic solvents, inorganic material, acids and alkalis, cyanides, hydrocarbons, precursors, unknown chemicals and materials, reactants and by-products of chemical processes and reactions to include gases, and controlled substances in solution or powdered form. Includes work indoors and outdoors in extremes of seasonal environmental temperatures and humidity. Prior acclimatization to hot or cold environments is unlikely.

If you find the individual cleared to wear respiratory personal protective equipment in accordance with 29 CFR 1910.134 and able to perform the duties described above, please sign and date the certification below and forward it with the results of your examination and related health screening reports to the Office of Attorney General.

#### MEDICAL CERTIFICATION

I have examined medically able to perform the duties described ab	on pove without unusual medical risk or harm	and find the individual to be n to the individual or others.
Physician's Signature:		Date:
Physician's Printed Name:		

## SUBJECT: REQUIRED MEDICAL EXAMINATIONS PA OAG, CRIMINAL LAW DIVISION (EVIDENCE CUSTODIANS)

Dear Doctor:

The purpose of this medical examination is to obtain a medical clearance for the below-listed individual to perform his/her duties as an Evidence Custodian with the Pennsylvania Office of Attorney General, Criminal Law Division.

The work place and environmental factors of concern are described below. Suggested guidelines for the annual medical evaluation have been provided to your examining facility.

<u>Type of Work</u>: In the course of official duties handles, packages, labels and stores controlled substances, drug paraphernalia, containers, firearms, ammunitions, knives, clothing, documents and other evidentiary items. The investigator maintains the inventory of evidentiary items. In addition, the investigator transports the subject items to and from a forensic laboratory and to a destruction facility. The size and weight of the items varies. Suggested guidelines for the annual medical evaluation have been provided to your examining facility

<u>Work Setting</u>: Maintains custody of the subject items in an interior evidence room that is ventilated. The potential for exposure to controlled substances, drug paraphernalia, glassware, firearms, ammunition, sharp objects, unknown substances/chemicals in various solids, liquids, powder/granular, plants/leaves/seeds in various storage containers and packages that are capable of releasing vapors is present.

If you find the individual cleared for performing the duties described above, please sign and date the certification below and forward it with the results of your examination and related health screening reports to the Office of Attorney General.

#### MEDICAL CERTIFICATION

I have examined medically able to perform the	on e duties described above without unusual medical risk or	and find the individual to be harm to the individual or others.
Physician's Signature:		Date:
Physician's Printed Name: _		

# APPENDIX F

A. Section 1. (Mandatory) Every employee de the following information.	who has been selected to use any type of respirator (please print)
Today's date	Date of Birth:
Name	SSN:
Job Title	Sex: Male Female
Home Phone:	Height: (ft) (in) Weight
Work Phone:	
Can you read English?	Yes () NO ()
• •	$\mathbf{O}$
	t the health care professional who will review this? Yes O NO O
Check the type of respirator you will use ()           a         N, R, or P disposable respirator (filter-m)	
a N, R, or P disposable respirator (filter-m	
b Other type	Powered-air purifier
Half-face	Supplied-air
Full-facepiece type (includes gas mask)	Self-contained breathing apparatus
Have you worn a respirator in the past?: .	Yes O NO O
If ``yes," what type(s):	
Physical exertion while wearing a respirate	or Mild Moderate Strenuous
Maximum time voli wear a resolizior in a	
Maximum time you wear a respirator in a Do you exercise?	Yes () NO ()
Do you exercise?	Pres O NO O
Do you exercise?	Pres NO Pres NO Pres NO Pres O NO PR
Do you exercise? If ``yes,' describe how often and what exe A. Section 2. (Mandatory) Questions 1 thro ted to use any type of respirator (please se	Pres NO Pres NO Pres NO Pres O NO PR
Do you exercise? If ``yes,' describe how often and what exe A. Section 2. (Mandatory) Questions 1 thro ted to use any type of respirator (please se 1. Do you currently smoke tobacco, or l	Precise activities are: Precise activities activiti
Do you exercise? If ``yes,' describe how often and what exe A. Section 2. (Mandatory) Questions 1 thro ted to use any type of respirator (please se 1. Do you currently smoke tobacco, or l	Yes       NO         prcise activities are:
Do you exercise? If ``yes,' describe how often and what exe A. Section 2. (Mandatory) Questions 1 thro ted to use any type of respirator (please se 1. Do you currently smoke tobacco, or 1 If Yes, how many packs per day? 1/2 o How many years have you smoked? 1-9	Yes       NO         vercise activities are:       Yes         ough 9 below must be answered by every employee who has been         elect ``yes" or ``no").         have you smoked tobacco in the last month?       Yes         I       I
Do you exercise? If ``yes,' describe how often and what exercise? A. Section 2. (Mandatory) Questions 1 through the following the fol	Yes       NO         vercise activities are:       Yes         ough 9 below must be answered by every employee who has been         elect ``yes" or ``no").         have you smoked tobacco in the last month?       Yes         I       I
Do you exercise? If ``yes,' describe how often and what exe A. Section 2. (Mandatory) Questions 1 thro ted to use any type of respirator (please se 1. Do you currently smoke tobacco, or 1 If Yes, how many packs per day? How many years have you smoked? 1.9 2. Have you ever had any of the following Seizures (fits)	Yes       NO         vorcise activities are:       Yes         bugh 9 below must be answered by every employee who has been         belect ``yes" or ``no").         have you smoked tobacco in the last month?         Yes       NO         or less       1         10-19       20-29         30 or more         ng conditions?
Do you exercise? If ``yes,' describe how often and what exercise? A. Section 2. (Mandatory) Questions 1 through the following the fol	Yes       NO         vorcise activities are:       Yes         ough 9 below must be answered by every employee who has been elect ``yes" or ``no").         have you smoked tobacco in the last month?       Yes         r less       1       2         10-19       20-29       30 or more         ng conditions?       Yes       NO         Yes       NO       Yes
Do you exercise? If ``yes,' describe how often and what exe A. Section 2. (Mandatory) Questions 1 thro ted to use any type of respirator (please se 1. Do you currently smoke tobacco, or   If Yes, how many packs per day? How many years have you smoked? 1.9 2. Have you ever had any of the following Seizures (fits) Diabetes (sugar disease)	Yes       NO         version activities are:       Yes       NO         ough 9 below must be answered by every employee who has been blect ``yes" or ``no").       NO       Yes       NO         have you smoked tobacco in the last month?       Yes       NO       Yes       NO         r less       1       2       2 or more       30 or more         10-19       20-29       30 or more       Yes       NO         ing       Yes       NO       Yes       NO       Yes       NO         ing       Yes       NO       Yes       Yes       NO       Yes       Yes       NO       Yes       Yes       NO       Yes       Yes       Yes       Yes       Yes       Yes       Yes       Yes
Do you exercise? If ``yes,' describe how often and what exe A. Section 2. (Mandatory) Questions 1 through the to use any type of respirator (please set 1. Do you currently smoke tobacco, or If Yes, how many packs per day? 1/2 o How many years have you smoked? 1-9 2. Have you ever had any of the following Seizures (fits) Diabetes (sugar disease) Allergic reactions that interfere with your breath	Yes       NO         version addy fill       Yes       NO         version activities are:       Second activities are:       Second activities are:         ough 9 below must be answered by every employee who has been elect ``yes" or ``no").       Second activities are:       Second activities are:         have you smoked tobacco in the last month?       Yes       NO       Second activities are:         n less       1       2       2 or more       Second activities are:         ing       Yes       NO       Yes       NO         ing       Yes       NO       Yes       NO
Do you exercise?	Yes       NO         vorcise activities are:       Yes         ough 9 below must be answered by every employee who has been elect ``yes" or ``no").         have you smoked tobacco in the last month?       Yes         have you smoked tobacco in the last month?       Yes         1       12       2 or more         10-19       20-29       30 or more         ng conditions?       Yes       NO         Yes       NO       Yes
Do you exercise? If ``yes,' describe how often and what exe A. Section 2. (Mandatory) Questions 1 thro ted to use any type of respirator (please se 1. Do you currently smoke tobacco, or 1 If Yes, how many packs per day? 1/2 o How many years have you smoked? 1-9 2. Have you ever had any of the following Seizures (fits) Diabetes (sugar disease) Allergic reactions that interfere with your breath Claustrophobia (fear of closed-in places) Trouble smelling odors	Yes       NO         vorcise activities are:       Yes         ough 9 below must be answered by every employee who has been elect ``yes" or ``no").         have you smoked tobacco in the last month?       Yes         have you smoked tobacco in the last month?       Yes         1       12       2 or more         10-19       20-29       30 or more         ng conditions?       Yes       NO         Yes       NO       Yes
Do you exercise?	Yes       NO         vorcise activities are:       Yes       NO         bugh 9 below must be answered by every employee who has been elect ``yes" or ``no").       NO       NO         have you smoked tobacco in the last month?       Yes       NO         in less       1       2       2 or more         10-19       20-29       30 or more         ng conditions?       Yes       NO         Yes       NO       Yes         Yes       NO       Yes         ing       Yes       NO         Yes       NO       Yes         Yes       NO       Yes         Yes       NO       Yes         Ing pulmonary or lung problems?       Yes
Do you exercise? If ``yes,' describe how often and what exe A. Section 2. (Mandatory) Questions 1 thro ted to use any type of respirator (please se 1. Do you currently smoke tobacco, or 1 If Yes, how many packs per day? 1/2 o How many years have you smoked? 1-9 2. Have you ever had any of the following Seizures (fits) Diabetes (sugar disease) Allergic reactions that interfere with your breath Claustrophobia (fear of closed-in places) Trouble smelling odors 3. Have you ever had any of the following Asbestosis	Yes       NO         vorcise activities are:       Yes       NO         bugh 9 below must be answered by every employee who has been blect ``yes'' or ``no'').       NO       NO         have you smoked tobacco in the last month?       Yes       NO         r less       1       2       2 or more         10-19       20-29       30 or more         ng conditions?       Yes       NO         Yes       NO       Yes         ing       Yes       NO         res       NO       Yes         ing       Yes       NO         Yes       NO       Yes
Do you exercise? If ``yes,' describe how often and what exercises,' describe how often and what exercises,' describe how often and what exercises,' describe how often and what exercises 1. Do you currently smoke tobacco, or left Yes, how many packs per day? If Yes, how many packs per day? If Yes, how many packs per day? How many years have you smoked? 1.9 2. Have you ever had any of the following Seizures (fits) Diabetes (sugar disease) Allergic reactions that interfere with your breath Claustrophobia (fear of closed-in places) Trouble smelling odors 3. Have you ever had any of the following Asbestosis Asthma	Yes       NO         version of the sectivities are:       Yes         ough 9 below must be answered by every employee who has been blect ``yes" or ``no").       have you smoked tobacco in the last month?         have you smoked tobacco in the last month?       Yes       NO         in less       1       2       2 or more         10-19       20-29       30 or more         ing       Yes       NO         Yes       NO       Yes         Yes       NO       Yes         Yes       NO       Yes         Yes       NO       Yes
Do you exercise? If ``yes,' describe how often and what exer A. Section 2. (Mandatory) Questions 1 through the to use any type of respirator (please sec 1. Do you currently smoke tobacco, or 1 If Yes, how many packs per day? 1/2 o How many years have you smoked? 1-9 2. Have you ever had any of the following Seizures (fits) Diabetes (sugar disease) Allergic reactions that interfere with your breath Claustrophobia (fear of closed-in places) Trouble smelling odors 3. Have you ever had any of the following Asbestosis Asthma Chronic bronchitis:	Yes       NO         vercise activities are:       Yes         ough 9 below must be answered by every employee who has been         blect ``yes" or ``no").         have you smoked tobacco in the last month?         Yes       NO         r less       1         10-19       20-29         30 or more         ng conditions?         Yes       NO
Do you exercise? If ``yes,' describe how often and what exer A. Section 2. (Mandatory) Questions 1 through teted to use any type of respirator (please set 1. Do you currently smoke tobacco, or 1 If Yes, how many packs per day? 1/2 o How many years have you smoked? 1-9 2. Have you ever had any of the following Seizures (fits) Diabetes (sugar disease) Altergic reactions that interfere with your breath Claustrophobia (fear of closed-in places) Trouble smelling odors 3. Have you ever had any of the following Asbestosis Asthma Chronic bronchitis: Emphysema;	Yes       NO         vrcise activities are:       Yes         ough 9 below must be answered by every employee who has been elect ``yes" or ``no").         have you smoked tobacco in the last month?       Yes         instant       1       2         10-19       20-29       30 or more         ing       Yes       NO         Yes       NO       Yes
Do you exercise? If ``yes,' describe how often and what exe A. Section 2. (Mandatory) Questions 1 thro ted to use any type of respirator (please se 1. Do you currently smoke tobacco, or   If Yes, how many packs per day? 1/2 o How many years have you smoked? 1-9 2. Have you ever had any of the following Seizures (fits) Diabetes (sugar disease) Allergic reactions that interfere with your breath Claustrophobia (fear of closed-in places) Trouble smelling odors 3. Have you ever had any of the following Asbestosis Asthma Chronic bronchitis: Emphysema: Pneumonia	Yes       NO         vrcise activities are:       Yes       NO         pugh 9 below must be answered by every employee who has been blect ``yes" or ``no").       have you smoked tobacco in the last month?       Yes       NO         have you smoked tobacco in the last month?       Yes       NO       Pression       Pression       NO         ing       1       1       2       2 or more       Pression
Do you exercise? If ``yes,' describe how often and what exe A. Section 2. (Mandatory) Questions 1 thro ted to use any type of respirator (please se 1. Do you currently smoke tobacco, or   If Yes, how many packs per day? 1/2 o How many years have you smoked? 1-9 2. Have you ever had any of the following Seizures (fits) Diabetes (sugar disease) Allergic reactions that interfere with your breath Claustrophobia (fear of closed-in places) Trouble smelling odors 3. Have you ever had any of the following Asbestosis Asthma Chronic bronchitis: Emphysema: Pneumonia Tuberculosis	Yes       NO         irrcise activities are:       Yes       NO         bugh 9 below must be answered by every employee who has been blect ``yes" or ``no").       have you smoked tobacco in the last month?       Yes       NO         have you smoked tobacco in the last month?       Yes       NO       Yes       NO         r less       1       2       2 or more       10-19       20-29       30 or more         ing       Yes       NO       Yes       NO       Yes       NO       Yes         ing       Yes       NO       <
Do you exercise?	Yes       NO         vrcise activities are:       Yes       NO         pugh 9 below must be answered by every employee who has been elect ``yes" or ``no").       have you smoked tobacco in the last month?       Yes       NO         have you smoked tobacco in the last month?       Yes       NO       Yes       NO         r less       1       2       2 or more       30 or more         Ing conditions?       Yes       NO       Yes       NO         yes       NO       Yes       NO       Yes       NO         ing       Yes       NO
Do you exercise? If ``yes,' describe how often and what exe A. Section 2. (Mandatory) Questions 1 through teted to use any type of respirator (please set 1. Do you currently smoke tobacco, or 1 If Yes, how many packs per day? 1/2 o How many years have you smoked? 1-9 2. Have you ever had any of the following Seizures (fits) Diabetes (sugar disease) Altergic reactions that interfere with your breath Claustrophobia (fear of closed-in places) Trouble smelling odors 3. Have you ever had any of the following Asbestosis Asthma Chronic bronchitis: Emphysema: Pneumonia Tubercutosis Silicosis Pneumothorax (collapsed lung)	Yes       NO         irrcise activities are:       Yes       NO         bugh 9 below must be answered by every employee who has been blect ``yes" or ``no").       have you smoked tobacco in the last month?       Yes       NO         have you smoked tobacco in the last month?       Yes       NO       Yes       NO         r less       1       2       2 or more       10-19       20-29       30 or more         ing       Yes       NO       Yes       NO       Yes       NO       Yes         ing       Yes       NO       <

(1)

	Name	
4. Do you currently have any of the following symp	toms of pulmonary or lung il	Iness?
Shortness of breath:		
Shortness of breath when walking fast on level ground or walking	up a slight hill/incline	
Shortness of breath when walking with other people at an ordinary		Yes 🔿 NO 🔿
Have to stop for breath when walking at your own pace on level gr	· · ·	
Shortness of breath when washing or dressing yourself:		Yes 🔿 NO 🦳
Shortness of breath that interferes with your job:	· · ·	
Coughing that produces phlegm (thick sputum):		
Coughing that wakes you early in the morning:		Yes 🔿 NO 🔿
Coughing that occurs mostly when you are lying down:		
Coughing up blood in the last month:		Yes 🚫 NO 🚫
Wheezing:		
Wheezing that interferes with your job:		Yes 🚫 NO 🚫
Chest pain when you breathe deeply:		
Any other symptoms that you think may be related to lung	· ·	Yes 🔿 NO 🔿
	· · · · · ·	· ·
5. Have you ever had any of the following cardiovasc	ular or heart problems?	
Heart attack		Yes O NO O
Stroke:	•	
Angina:		Yes O NO O
Heart Failure:	· .	
Swelling in your legs or feet (not caused by walking):		
Heart arrhythmia (heart beating irregularly):	· ·	
High blood pressure:		
Any other heart problem that you've been told about:		Yes () NO ()
6. Have you ever had any of the following cardiovasc	ular or heart symptoms?	
Frequent pain or tightness in your chest :	· · ·	Yes 🔿 NO 🔿
Pain or tightness in your chest during physical activity	· · ·	
Pain or tightness in your chest that interferes with your job	;	
In the past two years, have you noticed your heart skipping or miss	sing a beat :	Yes 🚫 NO 🚫
Heartburn or symptoms that is not related to eating		
Any other symptoms that you think may be related to heart or circu	ulation problems:	Yes NO
7. Do you currently take medication for any of the foll	lowing problems?	•
Breathing or lung problems:		Yes 🔿 NO 🔿
Heart trouble:		
Blood Pressure:		
Seizures(fits)::	, · · ·	Yes 🚫 NO 🚫
0 If we the weather have you are had any	of the following problems?	
8. If you've used a respirator, have you ever had any (If you've never used a respirator, check the followi		9)
Eye Irritation:		Yes O NO O
Skin allergies or rashes:		
Anxiety:		
General weakness or fatigue:		
Any other problem that interferes with your use of a respirator:		
9. Would you like to talk to the health care profession	al who will review this	
questionnaire about your answers to this question		' Yes () NO ()

(2)

Nan	ne
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This employee has been found to be physically able to use the following (check each [] that applies):         Single use, filter mask (four attachment points)       Full-faced powered cartridge-type (PAPR)         Half-faced cartridge-type, negative pressure       Self-contained breathing apparatus (SCBA)         Full-faced cartridge-type respirator, negative pressure       Hood/helmet powered cartridge-type (PAPR)         Half-faced powered cartridge-type (PAPR)       Half-faced/Full-faced/Hood/Helmet (NOT positive pressure         Insufficient informations (if any) when wearing a respirator:       Half-faced/Full-faced/Full-faced/Hood/Helmet (NOT positive pressure         Here is insufficient information to make a determination at this time       Here mandatory questionnaire has been reviewed, and the employee has been found to be physically able to use a respirator         Here mandatory questionnaire has been reviewed but there is insufficient information to make a determination at this tin	11. Do you currently have any of the following vision problems?       Yes       NO         Wear contact lenses:       Yes       NO         Color bildn:       Yes       NO         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?       Yes       NO         14. Have you ever had a back injury:       Yes       NO         15. Do you currently have any of the following musculoskeletal problems?       NO         16. Have you ever had a back injury:       Yes       NO         17. Do you currently have any of the following musculoskeletal problems?       NO         18. May our arms, hands, legs, or feet:       Back pain:       Yes       NO         Pain or stiffees when you lean forward or backward at the waist:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty fully moving your heads:       Yes       NO         Difficulty fully moving your heads ide to side:       Yes       NO         Difficulty fully moving your heads:       Yes       NO         Difficulty	0
Wear glasses:       Yes       N0         Color billed:       Yes       N0         Any other eye or vision problem:       Yes       N0         12. Have you ever had an injury to your ears, including a broken ear drum:       Yes       N0         13. Do you currently have any of the following hearing problems?       Yes       N0         Otificatly hearing:       Yes       N0         Yes       N0       Yes       N0         14. Have you ever had a back injury:       Yes       N0         15. Do you currently have any of the following musculoskeletal problems?       Yes       N0         14. Have you ever had a back injury:       Yes       N0       Pain or stiftness when you lean forward or backward at the waist:       Yes       N0         15. Do you currently have any of the following musculoskeletal problems?       Yes       N0       Pain or stiftness when you lean forward or backward at the waist:       Yes       N0       Pain or stiftness when you lean forward or backward at the waist:       Yes       N0       PDIfficulty fully moving your head up or down:       Yes       N0       PDIfficulty fully moving your head up or down:       Yes       N0       PDIfficulty fully moving your head up or down:       Yes       N0       PDIfficulty fully moving your head up or down:       Yes       N0       PDIfficulty fully moving your head side	Wear glasses:       Year ON         Wear contact lenses:       Year ON         Color bild:       Year ON         Any other eye or vision problem:       Year ON         12. Have you ever had an injury to your ears, including a broken ear drum:       Year ON         13. Do you currently have any of the following hearing problems?       Year ON         Difficulty hearing:       Year ON         Wear a hearing aid:       Year ON         Any other hearing or ear problem:       Year ON         14. Have you ever had a back injury:       Year ON         15. Do you currently have any of the following musculoskeletal problems?       Year ON         Wear hearing our arms, hands, legs, or feet:       Year ON         Back pain:       Year ON         Difficulty fully moving your arms, and legs:       Year ON         Pain or stillness when you lean forward or backward at the walst:       Year ON         Difficulty fully moving your head up or down:       Year ON         Difficulty fully moving your head is to side:       Year ON         Difficulty fully moving your heads:       Year ON         Difficulty fully moving your head:       Year ON         Difficulty fully moving your head:       Year ON         Difficulty fully moving your head:       Year ON         Difficulty ful	0
Wear contact lenses:       Yes       N0         Color billed:       Yes       N0         Any other eye or vision problem:       Yes       N0         12. Have you ever had an injury to your ears, including a broken ear drum:       Yes       N0         13. Do you currently have any of the following hearing problems?       Difficulty hearing:       Yes       N0         14. Have you ever had a back injury:       Yes       N0       N0         15. Do you currently have any of the following musculoskeletal problems?       Yes       N0         16. Do you currently have any of the following musculoskeletal problems?       Yes       N0         16. Do you currently have any of the following musculoskeletal problems?       Yes       N0         17. Do you currently have any of the following musculoskeletal problems?       Yes       N0         18. Do you currently have any of the following musculoskeletal problems?       Yes       N0         19. Difficulty faily moving your arms, hands, legs, or feet:       Yes       N0         19. Difficulty faily moving your arms and legs:       Yes       N0         10. Difficulty faily moving your head up or down:       Yes       N0         11. Difficulty faily moving your head is to aile:       Yes       N0         11. Difficulty faily moving your arms a ledge: carrying more than 28 lbs:	Wear contact lenses:       Yes       NO         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?       Yes       NO         Wear a hearing aid:       Yes       NO         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?       Yes       NO         Wear hearing aid:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Difficulty fully moving your head site to stackward at the waist:       Yes       NO         Difficulty fully moving your head site to stackward at the waist:       Yes       NO         Difficulty fully moving your head site to stack:       Yes       NO         Difficulty fully moving your head site to stack:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Climbing a flight of stairs or a ladder carrying more than 25 lise:       Yes       NO         Any additional comments you would like to make:       Yes       NO         O BE C	O'
Any other eye or vision problem:       Yes       N0         12. Have you ever had an injury to your ears, including a broken ear drum:       Yes       N0         13. Do you currently have any of the following hearing problems?       Utiliculty hearing:       Yes       N0         Wear a hearing aid:       Yes       N0       Yes       N0         Any other hearing or ear problem:       Yes       N0       Yes       N0         14. Have you ever had a back injury:       Yes       N0       Yes       N0         15. Do you currently have any of the following musculoskeletal problems?       Yes       N0       Back pair:         Difficulty fully moving your arms, hands, legs, or feet:       Yes       N0       Difficulty fully moving your head is legs:       Yes       N0         Pain or stiffness when you lean forward or backward at the watst:       Yes       N0       Difficulty fully moving your head is legs:       Yes       N0         Difficulty fully moving your head is legs:       Yes       N0       Difficulty fully moving your head is legs:       Yes       N0         Difficulty squatting to the ground:       Yes       N0       Difficulty squatting to the ground:       Yes       N0         Climbing a fight of stars or a ladder carrying more than 25 bis:       Yes       N0       NO       Any other muscl	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?       Yes       NO         Difficulty hearing:       Yes       NO         Any other hearing aid:       Yes       NO         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?       Yes       NO         Weakness in any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the waist:       Yes       NO         Difficulty fully moving your head yet or down:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty fully moving your meas       Yes       NO         Difficulty suttifies of the ground:       Yes       NO         Climbing a flight of stairs or a ladder carrying more then 25 lbs:       Yes       NO         Any additional comments y	Š
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?       Difficulty hearing:       Yes       NO         Wear a hearing aid:       Yes       NO       Yes       NO         Any other hearing or ear problem:       Yes       NO       Yes       NO         14. Have you ever had a back injury:       Yes       NO       Yes       NO         15. Do you currently have any of the following musculoskeletal problems?       Yes       NO       Yes       NO         15. Do you currently have any of the following musculoskeletal problems?       Yes       NO       Yes       NO         16. Do you currently have any of the following musculoskeletal problems?       Yes       NO       Yes       NO         16. Difficulty fully moving your arms, hands, legs, or feet:       Yes       NO       Yes       NO         Difficulty fully moving your head your down:       Yes       NO       Yes       NO       Yes       NO         Difficulty quity moving your head your down:       Yes       NO       Yes       NO       Yes       NO         Difficulty quity moving your head your down:       Yes       NO       Yes       NO       Yes       NO         D	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?       Difficulty hearing:       Yes       NO         Wear a hearing ald:       Yes       NO         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?       Yes       NO         Weakness In any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the waist:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty lifty moving your head side to side:       Yes       NO         Difficulty hilly moving you head side to side:       Yes       NO         Difficulty lifty moving you head side to side:       Yes       NO         Difficulty lifty moving you head side to side:       Yes       NO         Difficulty lifty moving you head side to side:       Yes       NO         Difficulty lifty moving you head side to side:       Yes       NO	ŏ
13. Do you currently have any of the following hearing problems?       Weile a hearing aid:       Yes       NO         Wear a hearing aid:       Yes       NO       Yes       NO         Any other hearing or car problem:       Yes       NO       Yes       NO         14. Have you ever had a back injury:       Yes       NO       Yes       NO         15. Do you currently have any of the following musculoskeletal problems?       Yes       NO         Weakness in any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO       Yes       NO         Pain or stiffness when you lean forward or backward at the walst:       Yes       NO       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO       Yes       NO       Yes       NO         Difficulty bending at your knees:       Use       Yes       NO       Yes       NO       Yes       NO         Difficulty bending at glight of stairs or a ladder canying more than 25 lbs:       Ary atter muscle or skeletal problem that interferes with using a respirator:       Yes       NO       Any atter muscle or skeletal problem that interferes with using a respirator:       Yes	13. Do you currently have any of the following hearing problems?       Ves       NO         Difficulty hearing:       Yes       NO         Any other hearing area problem:       Yes       NO         14. Have you ever had a back injury:       Yes       NO         15. Do you currently have any of the following musculoskeletal problems?       Yes       NO         15. Do you currently have any of the following musculoskeletal problems?       Yes       NO         Meakness in any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the walst:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Climbing allight of stales or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         To the best of my knowledge, the information 1 have provided is true and accurate.       Employee Signature       Date         This employee has been found t	ŏ
Difficulty hearing:       Yes       NO         Viker a hearing aid:       Yes       NO         Any other hearing or carproblem:       Yes       NO         14. Have you ever had a back injury:       Yes       NO         15. Do you currently have any of the following musculoskeletal problems?       Yes       NO         Weakness in any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the walst:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty banding at your knees:       Yes       NO         Difficulty banding at your knees:       Yes       NO         Difficulty banding at glight of stairs or a ladder canying more than 25 lbs:       Yes       NO         Any addritional comments you would like to make:       Yes       NO         Climbing a flight of stairs or a ladder canying more than 25 lbs:       Yes       NO         Any addritional comments you would like to make:       Yes       NO         Co       DECOMPLETED BY THE EXAMINER/REVIEWER:       Yes       NO         This employee has been found to be physi	Difficulty hearing:       Yes       NO         Any other hearing are ap problem:       Yes       NO         14. Have you ever had a back injury:       Yes       NO         15. Do you currently have any of the following musculoskeletal problems?       Yes       NO         Weakness in any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the walst:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty guatting to the ground:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Climbing a flight of stairs or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:       To       To the best of my knowledge, the information I have provided is true and accurate.         Employee Signature       Date       Date       Date       Date       Date       Date       Date       Da	0
Wear a hearing aid:       Yes       NO         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?       Yes       NO         Weakness in any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the walst:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head you or down:       Yes       NO         Difficulty fully moving your head you or down:       Yes       NO         Difficulty fully moving your head you or down:       Yes       NO         Difficulty fully moving your head you or down:       Yes       NO         Difficulty fully moving your head you or down:       Yes       NO         Difficulty fully moving your head you or down:       Yes       NO         Difficulty fully moving your head you or down:       Yes       NO         Difficulty fully moving your head you or down:       Yes       NO         Difficulty fully moving your head you or down: <td>Wear a hearing aid:       Yes       NO         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?       Yes       NO         Weakness in any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the weist:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your knees:       Yes       NO         Difficulty squating to the ground:       Yes       NO         Climbing a tight of statise or a ladder carrying more than 25 lbs:       Yes       NO         Any additional comments you would like to make:       Yes       NO         To the best of my knowledge, the information I have provided is true and accurate.       Employee Signature       Date         O EE COMPLETED BY THE EXAMINER/REVIEWER:       Self-contained breaking apparatus (SCEA)       Half-faced cartridge-type, negative pressure       Half-faced cartridge-type (PAPR)       Self-contained breaking apparatus (SCEA)       Half-faced cartridge-type, negative pressure       Half-faced full-</td> <td></td>	Wear a hearing aid:       Yes       NO         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?       Yes       NO         Weakness in any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the weist:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your knees:       Yes       NO         Difficulty squating to the ground:       Yes       NO         Climbing a tight of statise or a ladder carrying more than 25 lbs:       Yes       NO         Any additional comments you would like to make:       Yes       NO         To the best of my knowledge, the information I have provided is true and accurate.       Employee Signature       Date         O EE COMPLETED BY THE EXAMINER/REVIEWER:       Self-contained breaking apparatus (SCEA)       Half-faced cartridge-type, negative pressure       Half-faced cartridge-type (PAPR)       Self-contained breaking apparatus (SCEA)       Half-faced cartridge-type, negative pressure       Half-faced full-	
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?         Weakness in any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the walst:       Yes       NO         Difficulty fully moving your head bide to side:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Climbing a flight of stairs or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:	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?       Weakness in any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the waist:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty sequating to the ground:       Yes       NO         Climbing a flight of stairs or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:	$\leq$
14. Have you ever had a back injury:       Yes       NO         15. Do you currently have any of the following musculoskeletal problems?       Yes       NO         Weekness in any of your arms, hands, legs, or feet:       Yes       NO       Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the waist:       Yes       NO       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO       Yes       NO         Difficulty squatting to the ground:       Yes       NO       Yes       NO         Other muscle or skeletal problem that interferes with using a respirator:       Yes       NO       Yes       NO         Any additional comments you would like to make:	14. Have you ever had a back injury:       Yes       NO         15. Do you currently have any of the following musculoskeletal problems?       Weakness in any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO       Difficulty fully moving your arms and legs:       Yes       NO         Pain or silfness when you lean forward or backward at the waist:       Yes       NO       Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO       O       Difficulty fully moving your head side to side:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO       O       O       NO       O       NO       O       NO       NO <t< td=""><td><math>\leq</math></td></t<>	$\leq$
15. Do you currently have any of the following musculoskeletal problems?         Weakness In any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the waist:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty fully moving your head side to adde:       Yes       NO         Difficulty fully moving to a ladder carrying more than 25 lbs:       Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:	15. Do you currently have any of the following musculoskeletal problems?         Weakness In any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the waist:       Yes       NO         Difficulty fully moving your head us or down:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty bending at your knees:       Yes       NO         Olfificulty squatting to the ground:       Yes       NO         Climbing alight of statis or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:	Š
Weakness in any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the waist:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty bending at your knees:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Climbing a flight of stairs or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:	Weakness in any of your arms, hands, legs, or feet:       Yes       NO         Back pain:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the waist:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty bending at your knees:       Yes       NO         Olficulty gout head side to side:       Yes       NO         Difficulty bending at your knees:       Yes       NO         Olficulty gout arms at ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:	0
Back pain:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the waist:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty bending at your knees:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Climbing a flight of stairs or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:	Back pain:       Yes       NO         Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the waist:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty buily moving your head side to side:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Climbing a flight of stars or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:	
Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the waist:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Climbing a flight of stairs or a ladder carrying more than 25 lbs:       Yes       NO         Any additional comments you would like to make:       Yes       NO         To the best of my knowledge, the information I have provided is true and accurate.       Employee Signature       Date         O BE COMPLETED BY THE EXAMINER/REVIEWER:       This employee has been found to be physically able to use the following (check each [] that applies):         Single use, filter mask (four attachment points)       Full-faced powered cartridge-type (PAPR)         Half-faced cartridge-type negative pressure       Hod/helmet powered cartridge-type (PAPR)         Half-faced powered cartridge-type (PAPR)       Half-faced/Full-f	Difficulty fully moving your arms and legs:       Yes       NO         Pain or stiffness when you lean forward or backward at the waist:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty bending at your knees:       Yes       NO         Climbing a flight of tairs or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:	0
Pain or stiffness when you lean forward or backward at the waist:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Climbing a flight of stairs or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:	Pain or stiffness when you lean forward or backward at the waist:       Yes       NO         Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty fully moving at your knees:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Otimiting a flight of stairs or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:	0
Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty bending at your knees:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Climbing a flight of stairs or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:	Difficulty fully moving your head up or down:       Yes       NO         Difficulty fully moving your head side to side:       Yes       NO         Difficulty bending at your knees:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Climbing a flight of stairs or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:	0
Difficulty fully moving your head side to side:       Yes       NO         Difficulty bending at your knees:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Climbing a flight of stairs or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:       Yes       NO         To the best of my knowledge, the information I have provided is true and accurate.       Employee Signature       Date         O BE COMPLETED BY THE EXAMINER/REVIEWER:       Date       Date	Difficulty fully moving your head side to side:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Climbing a flight of stairs or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:       Yes       NO         To the best of my knowledge, the information I have provided is true and accurate.       Employee Signature       Date         O BE COMPLETED BY THE EXAMINER/REVIEWER:       Date	$\cup$
Difficulty bending at your knees:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Climbing a flight of stairs or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:       Yes       NO         To the best of my knowledge, the information I have provided is true and accurate.       Employee Signature       Date         O BE COMPLETED BY THE EXAMINER/REVIEWER:       Date	Difficulty bending at your knees:       Yes       NO         Difficulty squatting to the ground:       Yes       NO         Climbing a flight of stairs or a ladder carrying more than 25 lbs:       Yes       NO         Any other muscle or skeletal problem that interferes with using a respirator:       Yes       NO         Any additional comments you would like to make:       Yes       NO         To the best of my knowledge, the information I have provided is true and accurate.       Employee Signature       Date         O BE COMPLETED BY THE EXAMINER/REVIEWER:       Date	٩Q
Difficulty squatting to the ground: Yes   Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes   Any other muscle or skeletal problem that interferes with using a respirator: Yes   Yes NO   Any additional comments you would like to make:   To the best of my knowledge, the information I have provided is true and accurate.   Employee Signature Date   O BE COMPLETED BY THE EXAMINER/REVIEWER:   This employee has been found to be physically able to use the following (check each [] that applies):   Stell-contained breathing apparatus (SCBA)   Half-faced cartridge-type, negative pressure   Half-faced powered cartridge-type (PAPR)   Half-faced/Full-faced/Hood/Helmet (NOT positive pressure   Half-faced/Full-faced/Hood/Helmet (NOT positive pressure   Half-faced/Hood/Helmet (NOT positive pressure   Half-faced/Full-faced/Hood/Helmet (NOT positive pressure   Half-faced/Hood/Helmet (NOT positive pressure   Half-faced/Full-faced/Hood/Helmet (NOT positive pressure   Half-faced/Full-faced/Hood/Helmet (NOT positive pressure   Half-faced/Full-faced/Hood/Helmet (NOT positive pressure   Half-faced/Hood/Helmet information to make a deter	Difficulty squatting to the ground: Yes   Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes   Any other muscle or skeletal problem that interferes with using a respirator: Yes   Any additional comments you would like to make:   To the best of my knowledge, the information I have provided is true and accurate.   Employee Signature Date   O BE COMPLETED BY THE EXAMINER/REVIEWER:   This employee has been found to be physically able to use the following (check each [] that applies,   Single use, filter mask (four attachment points)   Half-faced cartridge-type, negative pressure   Self-contained breathing apparatus (SCBA)   Half-faced cartridge-type (PAPR)   Half-faced powered cartridge-type (PAPR)   Half-faced full-faced/Full-faced/Hood/Helmet (NOT positiv   Restrictions / Limitations (if any) when wearing a respirator:   In the employee has been found to be physically NOT able to use a respirator for there is insufficient information to make a determination at this time The mandatory questionnaire has been reviewed, and the employee has been found to be physically able to use the mandatory questionnaire has been reviewed but there is insufficient information to make a determination at this time The mandatory questionnaire has been reviewed but there i	O י
Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes   Any other muscle or skeletal problem that interferes with using a respirator: Yes   Any additional comments you would like to make:	Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes NO   Any other muscle or skeletal problem that interferes with using a respirator: Yes NO   Any additional comments you would like to make:   To the best of my knowledge, the information I have provided is true and accurate.   Employee Signature Date   O BE COMPLETED BY THE EXAMINER/REVIEWER: This employee has been found to be physically able to use the following (check each [] that applies,   Single use, filter mask (four attachment points) Full-faced powered cartridge-type (PAPR)   Half-faced cartridge-type, negative pressure Self-contained breathing apparatus (SCBA)   Hulf-faced powered cartridge-type (PAPR) Half-faced/Full-faced/Houd/Helmet (NOT positiv   Restrictions / Limitations (if any) when wearing a respirator: Half-faced/Full-faced/Houd/Helmet (NOT positiv   Restrictions / Limitations (if any) when wearing a respirator: Imate a determination at this time   In amodatory questionnaire has been reviewed, and the employee has been found to be physically able to use the found to be physically able to use the mandatory questionnaire has been reviewed but there is insufficient information to make a determination at this time	Q
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