Énergie NB Power

Respiratory Protection Program User's Health Screening

LAST Name:	FIRST Name:	Employee #
Company/Employer & Site (if applicable):		Department:

Respirator USER completes WHITE boxes. Fit Tester / Health Care Professional complete GREY boxes.

Respirator USER's Health Conditions

If you check "YES" to a, b or c - further assessment by a health care professional is required prior to respirator use. Please contact a Nurse within Corporates Total Health & Safety.

Important: Medical information is **NOT** to be recorded on this form.

Some conditions can seriously affect your ability to safely use a respirator. Do you have or do you experience any of the following condition(s) that may affect your respirator use?

Shortness of breath	Breathing difficulties	Chronic bronchitis	Emphysema
Lung disease	Chest pain on exertion	Heart problems	Allergies
Hypertension	Cardiovascular disease	Thyroid problems	Diabetes
Neuromuscular disease	Fainting spells	Dizziness/nausea	Seizures
Temperature susceptibility	Claustrophobia/fear of heights	Hearing impairment	Dentures
Panic attacks	Color blindness	Asthma	Prescription medication to control a condition
Vision impairment	Reduced sense of smell	Reduced sense of taste	
Back/neck problems	Facial features/skin conditions	Pacemaker	

a) Or any other condition(s) affecting respirator use? (Check YES or NO box only. **DO NOT SPECIFY**.) ☐Yes ☐No

b) Have you had previous difficulty while using a respirator? ☐Yes ☐No

c) Do you have any concerns about your future ability to use a respirator safely? ☐Yes ☐No

Respirator USER

☐ I know of no medical condition that might affect my ability to wear a respirator.

☐ I may have a condition that should be evaluated by a doctor.

Signature _____ Date (yyyy-mm-dd) _____

Health Care Professional (HCP) Primary Assessment (if required)

Assessment Date (yyyy-mm-dd): _____

Respirator use permitted? ☐ Yes ☐ No ☐ Uncertain

Referred to medical assessment? ☐ Yes ☐ No

Reassessment Date (yyyy-mm-dd): _____

Health Care Professional (HCP) Name (print): _____

Title: _____

Signature: _____

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Type of Respirator(s)

Type		LMS Tracking Code	Size
3M 6000 (half)	☐	004-104	
3M 6000 (full)	☐	004-121	
MSA Comfo Classic (half)	☐	004-103	
Gas Mask/Security (full)	☐	004-140	
Scott AV3000 (full)	☐	004-001	
N95 (Moldex, Model:_____)	☐		

Note: *The numbers displayed above are for administrative purposes and represent the 'Fit Test' course that will be entered into the Learning Management System (LMS).*

Expiry Date (yyyy-mm-dd): _____ (*Entered by Fit Tester*)

(2) year expiry

I have been instructed on and I fully understand the proper respirator Selection, Use & Care including donning and doffing for the respirator I was tested for.

Employee Name (print): _____

Employee Signature: _____

I am satisfied the above named employee has a competent understanding of the expectations surrounding respirator Selection, Use and Care.

Fit Tester Name (print): _____

Fit Tester Signature: _____