

OAKLEY



CALIFORNIA

Respiratory Protection Program

October 23, 2018

Cal/OSHA requires employers to develop programs to monitor employee exposure to potentially harmful levels of airborne contaminants and dangerous oxygen levels. Exposure levels to harmful contaminants and oxygen levels in atmospheric air are determined by the performance of air monitoring. Respirators are required in atmospheres that could contain less than 19.5% or more than 23.5% oxygen, in atmospheres that contain dusts, fibers, mists, fumes, gases, or vapors at harmful concentrations or when a hazardous material that requires a respirator as a protective device in accordance with Safety Data Sheets is in use. Respirator requirements also apply to confined spaces and specific contaminants such as asbestos, silica, and regulated carcinogens.

The City of Oakley is committed to maintaining an injury and illness free workplace, and is making every effort to protect our employees from harmful airborne substances and oxygen levels.

Whenever it is feasible to do so, we accomplish this through engineering controls such as ventilation or substitution with a less harmful substance, and through administrative controls such as limiting the duration of exposure. When these methods are not adequate or simply to minimize employee exposure to airborne substances, the City of Oakley will provide respirators to allow employees to breathe safely in potentially hazardous environments. We recognize that respirators have limitations and their successful use is dependent on an effective respiratory protection program. Our Respiratory Protection Plan is designed to: identify, evaluate, and control exposure to respiratory hazards; select and provide the appropriate respirators; and coordinate all aspects required for proper use, care, and maintenance of the equipment.

PLAN RESPONSIBILITY:

Accomplishing these goals requires a cooperative effort on the part of employees and of management.

MANAGEMENT RESPONSIBILITY:

Management will provide leadership by example and demonstrate interest by ensuring that adequate resources are available for effective implementation of our Respiratory Protection Plan. To reinforce our commitment we have assigned the Safety Officer as the plan administrator who has the authority and responsibility for overall management and administration of our Respiratory Protection Plan, which consists of the following:

- **Preparing, evaluating, and modifying the written Respiratory Protection Plan**
 - Our Respiratory Protection Plan begins with this written plan describing the procedures that we practice. Our respiratory protection program serves as a dynamic reflection of the constantly changing workplace and tasks. Suggestions and comments from employees about exposure conditions, respirators, personal health changes, and training issues will be addressed promptly. Also, we will conduct a formal annual audit of the entire program. The form Respiratory Plan Evaluation Worksheet ([Attachment A](#)) is used to document the evaluation and to record recommended changes.

- **Ensuring that airborne exposures are identified and surveillance and evaluation of airborne exposures is maintained**
 - The first task in the workplace is an exposure assessment to identify high/low oxygen levels, harmful airborne contaminants, their extent and magnitude, and how to control them. We must ensure that employee exposure does not exceed the permissible concentrations specified in the California Code of Regulations Title 8, Section 5155. [T8CCR 5155](#) This assessment requires a person who is professionally trained to evaluate the processes and procedures and to conduct exposure monitoring. Consequently, we may need to seek advice and assistance from outside resources. Results of these evaluations will be summarized on the form Identification and Location of Airborne Contaminant Exposures and Respirator Selection ([Attachment B](#)).
 - Additional evaluations are necessary if exposures change due to new materials, process changes, or other conditions which increase the degree of employee exposure or stress, and these evaluations will be added to the form

- **Ensuring that proper respirators are selected.**
 - When engineering and administrative means do not achieve the desired control, or in the event of an emergency when a respirator must be worn,

a NIOSH/MSHA-approved respirator must be selected and used for the kind of work being performed and hazards involved. A [Guide](#) to proper selection is published by CalOSHA and should be used as a reference when selecting respirators. To select the proper respirator that will provide the proper level of protection, compare the results of air monitoring tests against the PELs (Permissible Exposure Limits). PEL's can be found [here](#). If assistance is required with determination of the proper respirator and/or if multiple exposures exist for a single task, it is advised that the assistance of a knowledgeable vendor or Industrial Hygienist be sought.

- Use the form Identification and Location of Airborne Contaminant Exposures and Respirator Selection ([Attachment B](#)) to record the selected respirator.

- **Providing medical screenings for first time users and repeat medical screenings as required by California Code of Regulations Title 8 Section 5144. [T8CCR5144](#)**
 - An employee's health status must be evaluated prior to allowing respirator fit or use. The wearer's physical and medical condition, duration and difficulty of the tasks, toxicity of the contaminant, and type of respirator all affect an employee's ability to wear a respirator while working.
 - Each potential respirator wearer, will complete the form OSHA Respirator Medical Evaluation Questionnaire ([Attachment C](#)). The employee must be given the opportunity to complete the form confidentially, during normal working hours and at a place and time convenient to the employee.
 - The completed questionnaire along with required information must be delivered confidentially to the designated professional licensed healthcare provider (PHLCP), **U. S. Health Works located at 3140 Balfour Rd Suite C Brentwood, CA** for review and further action. To protect the employee's confidential health information, it is recommended that the employee be given the questionnaire, an information sheet with required information from the employer, and a pre-addressed postage paid envelope with instructions to complete the questionnaire, place the questionnaire along with the information sheet into the postage paid envelope and drop it into the mail box.
 - Alternatively, the employee may hand deliver the questionnaire with the information sheet in a sealed envelope to U.S. Health Works.

- Required information to be sent with the completed questionnaire:
 - Type and weight of respirator
 - Duration and frequency of the respirator's use (including its use for rescue or escape)
 - Expected physical work effort
 - Additional protective clothing or equipment that will be worn
 - Temperature and Humidity range that will be encountered while wearing the respirator
 - A copy of this written program
 - A copy of California Code of Regulations Title 8 Section 5144(e) [T8CCR5144 \(e\)](#)
 - If desired by the employee, the employee must be given the opportunity to discuss the questionnaire and the answers given by the employee with the Professional Licensed Healthcare Provider (PLHCP)
 - If, based upon the questionnaire, the PLHCP is of the opinion that the employee can safely wear a respirator, the PLHCP may complete [Attachment D](#) "PLHCP Respiratory Fitness Medical Evaluation" and return it to the City of Oakley's HR Division.
 - Based on answers to the questionnaire, if the PLHCP has doubt about the medical ability of the employee to safely wear and use a respirator, the PHLCP must conduct a physical examination and perform tests necessary to make such a determination.
 - Based on the physical examination and testing, the healthcare provider must provide a written opinion to the employer stating the employee is cleared to wear a respirator, not allowed to wear a respirator, or can wear a respirator with specific limitations. The written statement should also include the need, if any, for follow up medical evaluation and a statement stating that the employee was provided a written copy of the PHLCP's opinion. [Attachment D](#) "PLHCP Respiratory Fitness Medical Evaluation" may be used for this purpose.
 - A medical evaluation should be repeated if a wearer suffers a dramatic change in health such as a heart attack or onset of a respiratory disease, reports medical signs or symptoms while wearing a respirator, demonstrates difficulty while wearing the respirator, is advised by the PHLCP, program administrator or supervisor.
- **Ensuring that respirators are being worn and used properly.**
 - We will not permit any employee with facial hair that interferes with the face to facepiece seal or the function of the respirator valve to wear a respirator.

- We will not allow any employee with any facial condition that interferes with the face to facepiece seal or the function of the respirator valve to wear a respirator.
 - If an employee wears corrective glasses, goggles or other personal protective equipment, we will ensure that it is worn in a manner that does not interfere with the face to facepiece seal.
 - We will ensure that all employees perform user seal checks prior to each use as required in California Code of Regulations Title 8 Section 5144 Appendix B [T8CCR5144 \(b\)](#)
 - We will confirm the continued effectiveness of the respirators by monitoring respirator users during the performance of their tasks.
 - We will re-evaluate the effectiveness of the respirator when there is a change in the work area conditions, degree of exposure or stress.
 - We will make sure the employee leaves the work area when:
 - The employee detects a breakthrough, a change in resistance or a leak in the facepiece; or
 - An employee must change a filter, cartridge or canister element; or
 - An employee must wash their face or facepieces to prevent eye or skin irritation due to respirator use.
 - If the employee detects a breakthrough, a change in resistance or a leak in the facepiece, we will ensure that the respirator is replaced or repaired before the employee is allowed to return to the work area.
- **Ensuring respirator fit testing is conducted annually as required under California Code of Regulations Title 8 Section 5144 [T8CCR5144](#).**
 - After selection of the appropriate type of respirator and receiving written approval from the PHLCP verifying the employee's ability to work while wearing a respirator, a fit test is conducted to choose a proper fitting facepiece and determine the specific brand, model, and size for each employee. Several brands, models and/or sizes of a particular type of respirator may be necessary to ensure a proper fit for all wearers.
 - The presence of facial hair or any condition that interferes with the sealing of the facepiece to the face requires that the employee be disallowed from wearing a respirator
 - Quantitative fit testing numerically measures the face-piece fit and is the preferred alternative to qualitative fitting. It requires specialized equipment and properly trained personnel. Asbestos exposure requires a quantitative fit test.
 - Qualitative fit testing relies on the wearers' reaction or non reaction to a test agent.

- Fit testing must be carried out as specifically detailed in California Code of Regulations Title 8 Section 5144 Appendix A. [T8CCR5144\(a\)](#)
 - The form Respirator Selection Summary ([Attachment E](#)) must be used to summarize all respirator assignments.
- **Providing training as required under California Code of Regulations Title 8 Section 5144 [T8CCR5144](#)**
 - Once the correct respirator for the task is assigned, the wearer must be thoroughly trained.
 - Topics must include:
 - the need
 - proper fit and use
 - limitations
 - use in emergencies including malfunctions
 - donning and doffing
 - care and inspection
 - medical signs and symptoms that may limit use
 - pre-use user seal checks, OSHA has [mandatory guidelines](#) that must be followed
 - maintenance, and storage of the equipment.
 - Detailed instructions for use and care of the respirator are provided by the manufacturer with the equipment, and this information is to be used in the training.
 - The form Respirator User Training and Education (Attachment F) must be used to record the training provided.
 - Respirator training must be repeated annually or
 - when changes in the workplace occur or the type of respirator use make previous training obsolete
 - when an employees' knowledge or improper use of the respirator indicate a lack of proper training or knowledge retention
 - Any situation occurs that appears to show that retraining is needed to ensure safe use of the respirator.
- **Providing a copy of California Code of Regulations, Title 8, Section 5144, Appendix D [T8CCR5144D](#) to any employee who voluntarily wears a respirator to avoid hazards that are below threshold limits.**
- **Maintaining up to date records per the California Code of Regulations, Title 8, Section 5144 [T8CCR5144](#)**
 - All major components of our program are documented. Documentation will:

- verify that each activity has occurred;
 - evaluate the success of the program;
 - satisfy regulatory requirements.
- These records include:
 - program assessment;
 - the written program;
 - exposure determination;
 - respirator selection;
 - physical status evaluation;
 - fit testing;
 - respirator assignment;
 - training form.

To assist the plan administrator, certain aspects of the program may be delegated to others. All supervisors are responsible for carrying out the plan for employees under their supervision

EMPLOYEE RESPONSIBILITY:

We expect all employees to work conscientiously to carry out our Respiratory Protection Plan, which is an element of our Injury and Illness Prevention Plan.

Under this Respiratory Protection Program, an employee who is required to wear a respirator to perform certain job functions must:

- Assist management in identifying tasks which may present respiratory health hazards
- Complete the required Health Questionnaire and send it or deliver it to the City of Oakley's PLHCP
- Submit to any medical examinations or tests deemed necessary by the PLHCP to make a decision regarding the employees' medical ability to use the respirator safely
- Participate in initial and annual respirator fit testing

- Attend initial and annual respirator training

Employee must also:

- Inspect the respirator prior to each use
- Perform a user seal check prior each use of the respirator
- Use the respirator according to the training provided
- Clean, maintain, and store the respirator as trained
- Report any issues with the respirator to management
- Advise management of any possible issues with this plan, the administration of this plan, the respirator or the employees' use of the respirator

All employees who choose to voluntarily wear a respirator must read and understand the requirements of California Code of Regulations Title 8 Section 5144 [T8CCR5144\(d\)](#) and sign the acknowledgment form [Attachment G](#) to this plan

Corrective Actions:

What must be done?	Who is responsible?	When will it start/finish?

Date of Evaluation: _____

Name of Evaluator: _____

Department Evaluated: _____

This completed evaluation form must be retained until an evaluation is repeated and a new evaluation form is completed

**IDENTIFICATION AND LOCATION OF AIRBORNE CONTAMINANTS EXPOSURES
And RESPIRATOR SELECTION
CITY OF OAKLEY
ATTACHMENT B**

Task #	Date of Determination	Location	Operation/Task	Airborne Contaminant	Permissible Exposure Level	Measured Exposure Level	Respirator Selected including cartridge type if required
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

This form is to be kept current as tests and level determinations and selections are made/updated

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY) ATTACHMENT C



RR2

**MEDICAL RECOMMENDATIONS
FOR USE OF RESPIRATORY
PROTECTIVE EQUIPMENT**

Applicant/Employee: _____ Age: _____
 Position Title: _____
 Date of Evaluation: _____ Company: _____
 Contact: _____ Contact Telephone: _____
 Evaluation Content: Questionnaire Physical PFT X-Ray Other: _____

Based on the elements indicated above, I have evaluated the aforementioned person in accordance with the provisions of OSHA 29 CFR 1910.134, applicable to the use of respiratory protective equipment, and it is my opinion that he/she is: *(Check all that apply)*

Medically qualified for unrestricted use of the following respiratory protective devices:
CATEGORY I Self-Contained; Air-Supplied (Continuous Flow, Demand and Pressure Demand);
 Canister Mask; Chemical Cartridge and Mechanical Filter with and without Blower.

Medically qualified for restricted use of respiratory protective devices as indicated below:

CATEGORY II

Self-Contained	1-2 hours per day
Air-Supplied	
Continuous Flow	Unlimited
Demand	Up to 4 hours / day
Pressure Demand	Up to 4 hours / day
Canister Mask	1-2 hours per day
Chemical Cartridge	1-2 hours per day
Mechanical Filter	1-2 hours per day
Mechanical Filter w/ Blower	Unlimited

CATEGORY III

Self-Contained	Never
Air-Supplied	
Continuous Flow	Emergency only
Demand	Emergency only
Pressure Demand	Emergency only
Canister Mask	Never
Chemical Cartridge	Never
Mechanical Filter	Never
Mechanical Filter w/ Blower	Emergency only

In need of the following additional evaluation to assess qualification: _____
 In need of Medical Follow-Up Examinations as frequently as every: _____
to include: _____

COMMENTS:

Fitting Considerations: Facial hair Glasses/Contact lenses Dentures/Facial deformity

I hereby certify that in accordance with OSHA 29 CFR 1910.134, applicable to the use of respiratory protective equipment, I have informed the applicant/employee of the results of his/her evaluation and I have given him/her a copy of these recommendations.

Health Care Professional: Name: _____
 Signature: _____
 Date: _____

This form complies with OSHA requirements and with other similar state requirements for the use of respirators.



Occupational Safety and Health Administration (OSHA)
Respirator Medical Evaluation Questionnaire
(App. C 1910.134)
Mandatory

TO THE EMPLOYER. Affirmative answers to questions in Part A Section 2, except question 9, require a medical examination.
TO THE EMPLOYEE. Can you read? Yes No Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient for you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional that will review it.

Supplemental Information. To be provided by the employer regarding the use of respirator and the working conditions.

1. Employer Representative: _____ Telephone: _____

2. Respirator Type _____ Weight _____ Duration of Use _____ Frequency of Use _____

Expected physical effort: Light Effort (Sitting/standing while writing, performing light assembly work: or controlling machines)
 Moderate Effort (Sitting/standing/walking using tools, performing assembly work, lifting/pushing moderate loads)
 Heavy Effort (Lifting heavy loads (>35lbs.); shoveling; walking up an 8° grade, climbing stairs with a load)

Expected use of additional protective clothing and/or equipment while using the respirator. Yes No

If yes, describe: _____

Expected working conditions: Temperature Extremes Low: _____°F High: _____°F
Humidity Extremes Low: _____% High: _____%

Part A. Section 1. To be completed by all applicants/employees selected to use any type of respirator. Please print.

Name		Social Security #		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date
Address			City	State	Zip Code
			Job Title		
Telephone ()	Best time to reach you at this number	Date of Birth		Age	Height (ft. in.)
				Weight (lbs)	

1. Has your employer told you how to contact the health care Professional who will review this questionnaire? Yes No If

2. Check the type of respirator you will use. (Check all that apply)
 N, R, or P disposable respirator
 Other types (i.e. half or full-facepiece, powered-air purifying, supplied-air, self-contained breathing apparatus).

3. Have you worn a respirator? Yes No
If Yes, list what type(s)

Part A. Section 2. To be completed by all applicants/employees selected to use any type of respirator. Please circle Yes or No.

<p>1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes No</p> <p>2. Have you ever had any of the following conditions? a. Seizures (fits): Yes No b. Diabetes (sugar disease): Yes No c. Allergic reactions interfering with your breathing Yes No d. Claustrophobia (fear of closed-in places): Yes No e. Trouble smelling odors: Yes No</p> <p>3. Have you ever had any of the following pulmonary or lung problems? a. Asbestosis: Yes No b. Asthma: Yes No c. Chronic bronchitis: Yes No d. Emphysema: Yes No</p>	<p>e. Pneumonia: Yes No f. Tuberculosis: Yes No g. Silicosis: Yes No h. Pneumothorax (collapsed lung) Yes No i. Lung cancer: Yes No j. Broken ribs: Yes No k. Any chest injuries or surgeries: Yes No l. Other lung problems you've been told about? Yes No</p> <p>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</p>
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- | | | | | | |
|---|-----|----|--|-----|----|
| d. Have to stop for breath when working at your own pace on level ground: | Yes | No | physical activity: | Yes | No |
| e. Shortness of breath when washing or dressing yourself: | Yes | No | c. Pain or tightness in your chest that interferes with your job: | Yes | No |
| f. Shortness of breath interfering with your job: | Yes | No | d. In the past two years, have you noticed your heart skipping or missing a beat: | Yes | No |
| g. Coughing producing phlegm (thick sputum): | Yes | No | e. Heart burn or indigestion not related to eating: | Yes | No |
| h. Coughing that wakes you early in morning: | Yes | No | f. Any other symptoms that you think may be related to heart or circulation problems: | Yes | No |
| i. Coughing that occurs mostly when you are lying down: | Yes | No | 7. Do you currently take any medication for any of the following problems? | | |
| j. Coughing up blood in the last month: | Yes | No | a. Breathing or lung problems: | Yes | No |
| k. Wheezing: | Yes | No | b. Heart problems: | Yes | No |
| l. Wheezing that interferes with your job: | Yes | No | c. Blood pressure: | Yes | No |
| m. Chest pain when you breathe deeply: | Yes | No | d. Seizures (fits): | Yes | No |
| n. Any other symptoms that you think may be related to lung problems: | Yes | No | 8. Have you ever used a respirator? If Yes, have you had any of the following problems? | Yes | No |
| 5. Have you ever had any of the following cardiovascular or heart problems? | | | a. Eye irritation: | Yes | No |
| a. Heart attack: | Yes | No | b. Skin allergies or rashes: | Yes | No |
| b. Stroke: | Yes | No | c. Anxiety: | Yes | No |
| c. Angina: | Yes | No | d. General weakness or fatigue: | Yes | No |
| d. Heart failure: | Yes | No | e. Any other problems that interfere with your use of a respirator: | Yes | No |
| e. Swelling in your legs or feet (not caused by walking): | Yes | No | 9. Would you like to talk to the health care professional who will review this questionnaire about your answers? | Yes | No |
| f. Heart arrhythmia (heart beating irregularly): | Yes | No | | | |
| g. High blood pressure: | Yes | No | | | |
| h. Other heart problems 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 | | | | | |

Questions 10 to 15 must be completed by all applicants/employees selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees selected to use other types of respirators, answering these questions is voluntary. Please circle Yes or No.

- | | | | | | |
|---|-----|----|--|-----|----|
| 10. Have you ever lost vision in either eye (temporarily or permanently)? | Yes | No | 15. Do you currently have any of the following musculoskeletal problems? | | |
| 11. Do you currently have any of the following vision problems? | | | a. Weakness in any of your arms, hands, legs, or feet: | Yes | No |
| a. Wear contact lenses: | Yes | No | b. Back pain: | Yes | No |
| b. Wear glasses: | Yes | No | c. Difficulty fully moving your arms and legs: | Yes | No |
| c. Color blind: | Yes | No | d. Pain or stiffness when you leaning forward or backward at the waist: | Yes | No |
| d. Any other eye or vision problem: | Yes | No | e. Difficulty fully moving your head up or down: | Yes | No |
| 12. Have you ever injured your ears, including a broken ear drum? | Yes | No | f. Difficulty fully moving your head side to side: | Yes | No |
| 13. Do you currently have any of the following hearing problems? | | | g. Difficulty bending at your knees: | Yes | No |
| a. Difficulty hearing: | Yes | No | h. Difficulty squatting to the ground: | Yes | No |
| b. Wear a hearing aid: | Yes | No | i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: | Yes | No |
| c. Any other hearing or ear problem: | Yes | No | j. Any other muscle or skeletal problem that interferes with using a respirator: | Yes | No |
| 14. Have you ever had a back injury? | Yes | No | | | |

Patient Signature: _____ Date: _____

Healthcare Professional

Name _____

Address _____

Signature _____

Date _____



SPIROMETRY PRE-SCREENING QUESTIONNAIRE

Patient Name: _____ SS #: _____ Date: _____

Height: _____ (inches) Weight: _____ (lbs) Blood Pressure: _____ / _____ (mm Hg)

QUESTIONNAIRE: Please answer the following questions as accurately as possible.
Cuestionario: Por favor conteste las siguientes preguntas lo mejor posible.

- Yes(Si) No 1. In the last 6 weeks have you had a chest injury or surgery involving the eye, ear, chest, abdomen or been hospitalized for a heart attack? *If Yes, we will schedule spirometry in 6 weeks.*
¿En las últimas tres semanas, ha sufrido usted lesiones en el pecho u operaciones en ojos, oídos, pecho, abdomen o ha sido hospitalizado por ataque al corazón? En caso afirmativo, pospondremos la espirometría para dentro de 6 semanas.
- Yes(Si) No 2. Are you under a physician's care for high blood pressure? If blood pressure exceeds action level, we must obtain physician clearance before proceeding.
¿Esta usted bajo tratamiento por presión arterial alta? Si la presión excede cierto nivel, necesitamos una autorización de su médico tratante.
- Yes(Si) No 3. Within the last hour have you smoked tobacco? If Yes, and if possible, wait one hour before testing, Otherwise, make notation to physician and proceed.
¿Ha fumado usted durante la última hora? En caso afirmativo, debemos esperar una hora antes de hacerle la prueba. Si no es posible, lo notaremos por escrito y procederemos.
- Yes(Si) No 4. Within the last hour have you eaten a full meal? If Yes, if possible, wait one hour before testing, otherwise make notation to physician and proceed.
¿Ha comido usted una comida completa durante la última hora? En caso afirmativo, debemos esperar una hora antes de hacerle la prueba. Si no es posible, lo notaremos por escrito y procederemos.
- Yes(Si) No 5. Have you had a respiratory infection (chest cold, flu, bronchitis or pneumonia) in the last 3 weeks? *If Yes, continue with spirometry testing and make notation to physician.*
¿Ha tenido una infección respiratoria (pecho, resfriado, flú, bronquitis o neumonía) en las últimas tres semanas? En caso afirmativo, debemos esperar una hora antes de hacerle la prueba. Si no es posible, lo notaremos por escrito y procederemos.
- Yes(Si) No 6. Have you used an inhaled bronchodilator (Primatene Mist, Ventolin) in the last 6 hours?
¿Ha usado un agente broncodilatador (Primatene Mist, Ventolin) en las últimas 6 horas?
- Yes(Si) No 7. Are you wearing any tight or restrictive clothing?
¿Lleva puesta usted ropa apretada o restrictiva?
- Yes(Si) No 8. Are you wearing dentures?
¿Utiliza usted dentadura postiza?

Technician Comments

Performed by: _____ Name: _____ Initials: _____

Supervising Physician: _____ Name: _____

PART B:

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes/No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes/No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No

If "yes," name the chemicals if you know them:

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

- a. Asbestos: Yes/No
- b. Silica (e.g., in sandblasting): Yes/No
- c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No
- d. Beryllium: Yes/No
- e. Aluminum: Yes/No
- f. Coal (for example, mining): Yes/No
- g. Iron: Yes/No
- h. Tin: Yes/No
- i. Dusty environments: Yes/No
- j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures:

4. List any second jobs or side businesses you have:

5. List your previous occupations:

6. List your current and previous hobbies:

7. Have you been in the military services? Yes/No

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you ever worked on a HAZMAT team? Yes/No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes/No

If "yes," name the medications if you know them:

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters: Yes/No

b. Canisters (for example, gas masks): Yes/No

c. Cartridges: Yes/No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

a. Escape only (no rescue): Yes/No

b. Emergency rescue only: Yes/No

c. Less than 5 hours per week: Yes/No

d. Less than 2 hours per day: Yes/No

e. 2 to 4 hours per day: Yes/No

f. Over 4 hours per day: Yes/No

12. During the period you are using the respirator(s), is your work effort:

a. Light (less than 200 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: ___ hrs. ___ mins.

Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.

b. Moderate (200 to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: ___ hrs. ___ mins.

Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. Heavy (above 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: ___ hrs. ___ mins.

Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or

chipping castings; walking up an 8- degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using the respirator: Yes/No

If "yes," describe this protective clothing and/or equipment:

14. Will you be working under hot conditions (temperature exceeding 77 deg. F):
Yes/No

15. Will you be working under humid conditions: Yes/No

16. Describe the work you'll be doing while you're using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

The name of any other toxic substances that you'll be exposed to while using your respirator:

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

Employee Name: _____

Employee Signature: _____

Today's Date: _____

**PLHCP RESPIRATORY FITNESS MEDICAL EVALUATION
CITY OF OAKLEY
ATTACHMENT D**

To the PLHCP:

1) Please return this form to:

City of Oakley
Attn: Human Resources
3231 Main St
Oakley, CA 94561

2) Please provide a copy of this form to the employee for their records

3) Please maintain a copy of this form with your medical record for this employee

Based upon my examination, tests performed, and/or information provided to me by the employee and City of Oakley, it is my medical opinion that:

Name of Employee: _____

has a medical condition that prohibits them from wearing a respirator

may wear a respirator without restriction

may wear a respirator but only when following the restrictions listed below:

- _____
- _____
- _____
- _____

PLHCP signature: _____

Date: _____

**RESPIRATOR USER TRAINING
CITY OF OAKLEY
ATTACHMENT F**

This form is to be completed and signed by the user student and instructor upon the conclusion of training

1. The respirator user was instructed in the nature of the hazards for which this respirator is being provided, and informed of possible consequences that may occur if exposed to the hazard without adequate protection.
2. Health hazard guidelines are contained in the training program and Safety Data Sheets.
3. The respirator user will also be made aware of other methods used to reduce or eliminate the hazard.
4. Instruction will cover the respirator's capabilities and limitations, and the function and possible malfunction of each part of the respirator.
5. The respirator user was instructed in his/her responsibility for equipment inspection prior to use. All required points of inspection were included.
6. Each respirator user will use their respirator during this part of the training, and learn how to obtain replacement parts or new equipment.
7. Instruction was given on donning/doffing methods, proper fitting, and adjustment of the equipment.
8. Instruction and training covered proper respirator cleaning storage and maintenance,
9. Instruction and training was given to the employee regarding user seal checks and the requirement for this check each time the equipment is donned.

By signing below, I attest that I have been properly trained in respirator use, I understand the training and I was given an opportunity to ask questions. I also attest that I will use the respirator in the manner in which I was taught and for the purpose intended. I acknowledge it is my responsibility to care for, maintain and store this equipment as trained.

Date of Training	Employee Name	Department	Signature

As the instructor of this class, I attest that I have provided all required information to the student and the student(s) has/have demonstrated the proper methods for inspection, donning, doffing and using the respirator. The student has also been provided information about the care, maintenance and storage of the respirator.

Trainer Signature: _____ Date of Instruction: _____

This form must be completed and updated as training occurs and maintained on file.

**CALIFORNIA CODE OF REGULATIONS, TITLE 8, SECTION 5144 APPENDIX D
ACKNOWLEDGMENT
CITY OF OAKLEY
ATTACHMENT G**

By signing below, I acknowledge that I am wearing a respirator while performing certain tasks. This is being done voluntarily and I am not required to wear a respirator while performing those tasks.

I understand that I am responsible for selection of the mask I am wearing, for inspecting, donning/doffing, using, cleaning, caring, maintaining and storing the respirator in the proper manner per the manufacturers' instructions. I also acknowledge that performing a user seal check is required by Cal OSHA regulation and therefore I am strongly encouraged to perform the user seal check prior to each use.

I have received, read, and understood the OSHA required information about voluntary respirator use in [Title 8, Section 5144, Appendix D](#).

Employee Name: _____

Employee Signature: _____

Today's Date: _____

City of Oakley

RESPIRATORY PROTECTION PROGRAM

I acknowledge that I have read the City of Oakley's Respiratory Protection Program including the section on Voluntary (Comfort) Respirator Use. I understand and agree that it is my responsibility to read and familiarize myself with the provisions of this document, to follow the established procedures and participate in the program (medical clearance, fittings, and trainings) as provided.

Furthermore, I understand that it is my duty as an employee of the City of Oakley to immediately report any safety concerns to my supervisor or other responsible department management staff.

Employee Name: _____

Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

This document must be kept on file in the user's department respiratory protection records.