FORMS

Occupational Health

Providence | Health System

A caring difference you can feel

174558

Providence | Health System

Providence Occupational Health

Respirator Usage Information Form

Company: _____

Position: _____

Type of respirator:

- ☐ Filter mask, non-cartridge
- ☐ Half or full face piece
- ☐ Powered air purifying
- ☐ Supplied air
- ☐ Self-contained breathing apparatus

Duration and frequency of respirator use:
_____ hours/day _____ days/week

Activities performed during respirator use:

_____

_____

_____

Environment during respirator use (i.e., extremes in temperature or humidity):

_____

_____

_____

Exposures encountered:

_____

_____

_____

Any additional protective equipment worn:

_____

_____

☐ **Parkrose**
3510 NE 122nd Ave.
Suite 102
Portland, OR 97203
Tel: (503) 215-6378
Fax (503) 215-6572

☐ **Northwest**
1750 NW Naito Parkway
Suite 100
Portland, OR 97209
Tel: (503) 227-7562
Fax: (503) 227-6138

☐ **Tanasbourne**
1881 NW 185th Ave.
Suite 204
Aloha, OR 97006
Tel: (503) 614-0217
Fax: (503) 614-0816

☐ **Clackamas**
15775 SE 82nd Dr.
Clackamas, OR 97015
Tel: (503) 656-4666
Fax: (503) 656-0675

Providence Health System
Occupational Health

RESPIRATOR QUESTIONNAIRE COVER SHEET

PATIENT INFORMATION

Name _____

Company _____

Date _____

Social security number _____ - _____ - _____

Date of birth _____

Gender _____ M _____ F

PROVIDENCE OCCUPATIONAL HEALTH CLINICS:

❑ **PARKROSE**
3510 NE 122nd Ave.
Suite #102
Portland, OR 97230
Tel: (503) 215-6378
Fax: (503) 215-6572

❑ **TANASBOURNE**
1881 NW 185TH Ave.
Suite #204
Aloha, OR 97006
Tel: (503) 614-0217
Fax: (503) 614-0816

❑ **NORTHWEST**
1750 NW Naito Pkwy.
Suite #100
Portland, OR 97209
Tel: (503) 227-7562
Fax: (503) 227-6138

❑ **CLACKAMAS**
15775 SE 82ND Dr.
Clackamas, OR 97015
Tel: (503) 656-4666
Fax: (503) 656-0675

Providence | Health System

PROVIDENCE OCCUPATIONAL HEALTH

OSHA Respirator Medical Evaluation Questionnaire (mandatory)

To the employer: Answers to questions in Section 1 and to question 9 in Section 2, Part A, do not require a medical examination.

(Please check yes or no)
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 to 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 who will review it.

Part A. Section 1.

1. Today's date: _____
2. Your name: _____
3. Your age (to nearest year) : _____
4. Gender (check one): ☐ male ☐ female
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Your job title: _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code) _____ - _____ - _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire (check one): ☐ yes ☐ no
11. Check the type of respirator you will use (you can check more than one category):
    a. N, R, or P disposable respirator (filter-mask, non-cartridge type only) ☐
    b. Other type (for example, half- or full-face-piece type, powered-air purifying, supplied air, self-contained breathing apparatus) ☐
12. Have you worn a respirator before? (check one) ☐ yes ☐ no
    If "yes," what type(s):

    _____

    _____

Part A. Section 2.

(Mandatory)
Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. Please check yes or no.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐ yes ☐ no

2. Have you ever had any of the following conditions?
   a. Seizures (fits) ☐ yes ☐ no
   b. Diabetes (sugar disease) ☐ yes ☐ no
   c. Allergic reactions that interfere with your breathing ☐ yes ☐ no
   d. Claustrophobia (fear of closed-in places) ☐ yes ☐ no
   e. Trouble smelling odors ☐ yes ☐ no

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
   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. Any other lung problem that you've been told about ☐ yes ☐ no

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
   d. Have to stop for breath when walking at your own pace on level ground ☐ yes ☐ no
   e. Shortness of breath when washing or dressing yourself ☐ yes ☐ no
   f. Shortness of breath that interferes with your job ☐ yes ☐ no
   g. Coughing that produces phlegm (thick sputum) ☐ yes ☐ no
   h. Coughing that wakes you early in the morning ☐ yes ☐ no
   i. Coughing that occurs mostly when you are lying down ☐ yes ☐ no
   j. Coughing up blood in the last month ☐ yes ☐ no
   k. Wheezing ☐ yes ☐ no
   l. Wheezing that interferes with your job ☐ yes ☐ no
   m. Chest pain when you breathe deeply ☐ yes ☐ no
   n. Any other symptoms that you think may be related to lung problems ☐ yes ☐ no

5. Have you ever had any of the following cardiovascular or heart symptoms?

a.	Heart attack	☐ yes ☐ no
b.	Stroke	☐ yes ☐ no
c.	Angina	☐ yes ☐ no
d.	Heart failure	☐ yes ☐ no
e.	Swelling in your legs or feet (not caused by walking)	☐ yes ☐ no
f.	Heart arrhythmia (heart beating irregularly)	☐ yes ☐ no
g.	High blood pressure	☐ yes ☐ no
h.	Any other heart problem that 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 physical activity	☐ yes ☐ no
c.	Pain or tightness in your chest that interferes with your job	☐ yes ☐ no
c.	In the past two years, have you noticed your heart skipping or missing a beat	☐ yes ☐ no
e.	Heartburn or indigestion that is not related to eating	☐ yes ☐ no
f.	Any other symptoms that you think may be related to heart or circulation problems	☐ yes ☐ no

7. Do you currently take medication for any of the following problems?

a.	Breathing or lung problems	☐ yes ☐ no
b.	Heart trouble	☐ yes ☐ no
c.	Blood pressure	☐ yes ☐ no
d.	Seizure (fits)	☐ yes ☐ no

8. If you've used a respirator, have you ever had any of the following problems?

(If you've never used a respirator, check here and skip to question 9): ☐

a.	Eye irritation	☐ yes ☐ no
b.	Skin allergies or rashes	☐ yes ☐ no
c.	Anxiety	☐ yes ☐ no
d.	General weakness or fatigue	☐ yes ☐ no
d.	Any other problem that interferes with your use of a respirator	☐ yes ☐ no

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? ☐ yes ☐ no

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently) ☐ yes ☐ no

11. Do you currently have any of the following vision problems?
    a. Wear contact lenses ☐ yes ☐ no
    b. Wear glasses ☐ yes ☐ no
    c. Color blind ☐ yes ☐ no
    d. Any other eye or vision problem ☐ yes ☐ no

13. Have you ever had an injury to your ears, including a broken ear drum? ☐ yes ☐ no

14. Do you currently have any of the following hearing problems?
    a. Difficulty hearing ☐ yes ☐ no
    b. Wearing a hearing aid ☐ yes ☐ no
    c. Any other hearing problem ☐ yes ☐ no

14. Have you ever had a back injury? ☐ yes ☐ no

15. Do you currently have any of the following musculoskeletal problems?
    a. Weakness in any of your arms, hands, legs, or feet ☐ yes ☐ no
    b. Back pain ☐ yes ☐ no
    c. Difficulty fully moving your arms and legs ☐ yes ☐ no
    d. Pain or stiffness when you lean forward or backward at the waist ☐ yes ☐ no
    e. Difficulty fully moving your head up or down ☐ yes ☐ no
    f. Difficulty fully moving your head side to side ☐ yes ☐ no
    g. Difficulty bending your knees ☐ yes ☐ no
    h. Difficulty squatting to the ground ☐ yes ☐ no
    i. Climbing a flight of stairs or a ladder carrying more than 25 pounds ☐ yes ☐ no
    j. Any other muscle or skeletal problem that interferes with using a respirator ☐ yes ☐ no

---

I authorize my prospective/current employer and his designated medical facility to perform an evaluation as deemed necessary or requested by my prospective/current employer to determine my suitability for respirator use. In addition, I authorize the release to my prospective/current employer the results of this evaluation to enable my prospective/current employer to evaluate my current medical condition and suitability for respirator use. I understand that misstatement or omission of information could endanger my health by promoting a misinformed medical determination to my prospective/current employer. I further understand that this evaluation is specific for my use of respirators and is not meant to take the place of routine medical health evaluations.

SIGNATURE: _____ **DATE:** _____

174558

Providence | Health System

RESPIRATOR MEDICAL CERTIFICATION

NAME _____

SOCIAL SECURITY NUMBER _____

EMPLOYER _____

POSITION _____

DATE EVALUATED _____

The above named individual has on this date undergone a medical evaluation for his or her ability to wear a respirator. This evaluation included:

☐ **OSHA Respirator Questionnaire (Mandatory).**

☐ **OSHA Respirator/Questionnaire (Mandatory) -AND- Medical Examination.**

Based on this evaluation:

☐ **No limitations exist that prohibit this individual from using respiratory protective equipment.**

☐ **A Medical Examination is indicated for this employee.**

☐ **The following limitations in the use of respiratory protective equipment exist.**

_____

_____

_____

*** Follow-up Medical Evaluation recommended in** _____

<u>The employee has been provided with a copy of this written recommendation</u>

*** Additional Medical Evaluation** should be provided for this employee if:

(i) He or she reports medical signs or symptoms related to the ability to use a respirator;

(ii) A physician or other licensed health care professional, supervisor or the respirator program administrator informs the employer that an employee needs to be re-evaluated;

(iii) Information from the respiratory protection program, including observation made from fit testing and program evaluation, indicates a need for employee re-evaluation;

(iv) A change occurs in workplace conditions (e.g., physical work effort, protective clothing, temperature) that may result in a substantial increase in the physiologic burden placed on an employee.

Physician or Licensed Health Care Professional signature _____ *Date* _____

☐ **PROVIDENCE OCCUPATIONAL HEALTH - TANASBOURNE**
1881 N.W. 185th SUITE # 204
ALOHA, OREGON 97006
TEL. 503.614.0217 FAX 503.614.0816

☐ **PROVIDENCE OCCUPATIONAL HEALTH - NORTHWEST**
1750 N. W. NAITO PKWY SUITE # 100
PORTLAND, OREGON 97209
TEL. 503.227.7562 FAX 503.227.6138

☐ **PROVIDENCE OCCUPATIONAL HEALTH - PARKROSE**
3510 N.E. 122nd AVE. SUITE # 102
PORTLAND, OREGON 97230
TEL. 503.215.6378 FAX 503.215.6572

☐ **PROVIDENCE OCCUPATIONAL HEALTH - CLACKAMAS**
15775 S.E. 82nd DRIVE
PORTLAND, OREGON 97015
TEL. 503.656.4666 FAX 503.656.0675

Occ Health RMC.f3f *9/99 PHS Printing Services 215-5356 Fax 215-5358

174558

Providence Health System

MEDICAL EXAMINATION FORM

NAME _____

SOCIAL SECURITY NUMBER _____

EMPLOYER _____

POSITION _____

DATE EVALUATED _____

TYPE OF EXAM: ☐ PRE-PLACEMENT ☐ EXECUTIVE ☐ MEDICAL SURVEILLANCE ☐ OTHER:

HEIGHT	WEIGHT	BLOOD PRESSURE		PULSE	TEMP
IN.	LBS.	1st	2nd		F

VISUAL SCREENING

UNCORRECTED		CORRECTED		COLOR VISION
FAR	NEAR	FAR	NEAR	TEST: ☐ SCREEN RED, GREEN, YELLOW ☐ ISHIHARA
BOTH 20/	20/	BOTH 20/	20/	
R 20/	20/	R 20/	20/	RESULT: ☐ NORMAL ☐ DEFICIT PRESENT
L 20/	20/	L 20/	20/	

HEARING ADEQUATE TO CONVERSATION? ☐ YES ☐ NO AUDIOGRAM ADMINISTERED? ☐ YES ☐ NO

	NORMAL	ABNORMAL	COMMENTS
1. HEAD & FACE	☐	☐	
2. EYES	☐	☐	
3. EARS	☐	☐	
4. NOSE	☐	☐	
5. MOUTH	☐	☐	
6. NECK	☐	☐	
7. CHEST / LUNG	☐	☐	
8. HEART	☐	☐	
9. ABDOMEN	☐	☐	
10. GENITALIA / HERNIA	☐	☐	
11. EXTREMITIES	☐	☐	
12. MUSCULOSKELETAL	☐	☐	
13. SPINE	☐	☐	
14. NEUROLOGICAL	☐	☐	
15. SKIN	☐	☐	
16. OTHER _____	☐	☐	

PLEASE CONTINUE ON REVERSE SIDE

☐ **PROVIDENCE OCCUPATIONAL HEALTH - TANASBOURNE**
1881 N.W. 185th SUITE # 204
ALOHA, OREGON 97006
TEL. 503.614.0217 FAX 503.614.0816

☐ **PROVIDENCE OCCUPATIONAL HEALTH - PARKROSE**
3510 N.E. 122nd AVE. SUITE # 102
PORTLAND, OREGON 97230
TEL. 503.215.6378 FAX 503.215.6572

☐ **PROVIDENCE OCCUPATIONAL HEALTH - NORTHWEST**
1750 N. W. NAITO PKWY SUITE # 100
PORTLAND, OREGON 97209
TEL. 503.227.7562 FAX 503.227.6138

☐ **PROVIDENCE OCCUPATIONAL HEALTH - CLACKAMAS**
15775 S.E. 82nd DRIVE
PORTLAND, OREGON 97015
TEL. 503.656.4666 FAX 503.656.0675

PHS Printing Services 215-5356 Fax 215-5358
Occ Health mef.fm *2/2000

174558

Providence | Health System

REQUEST FOR MEDICAL RECORDS

NAME _____

SOCIAL SECURITY NUMBER _____

EMPLOYER _____

POSITION _____

DATE EVALUATED _____

In order for Providence Occupational Health To complete the medical evaluation requested by your prospective/current employer, the following medical records are required for review by the physician:

- ☐ History and Physical Reports
- ☐ Lab/X-Ray Reports
- ☐ Surgery/Operative Reports
- ☐ Medication Summary
- ☐ Progress Notes for Illness/Injury Treatment _____
- ☐ Other:

Please have these records sent to us as soon as possible. Records may be received via our confidential FAX at the number indicated below.

These records **MUST BE RECEIVED within 10 DAYS** of the date of this request. In the event that these records do not arrive within this time frame, we will notify your prospective/current employer that we are unable to complete your evaluation.

☐ **PROVIDENCE OCCUPATIONAL HEALTH - TANASBOURNE**
1881 N.W. 185th SUITE # 204
ALOHA, OREGON 97006
TEL. 503.614.0217 FAX 503.614.0816

☐ **PROVIDENCE OCCUPATIONAL HEALTH - PARKROSE**
3510 N.E. 122nd AVE. SUITE # 102
PORTLAND, OREGON 97230
TEL. 503.215.6378 FAX 503.215.6572

☐ **PROVIDENCE OCCUPATIONAL HEALTH - NORTHWEST**
1750 N. W. NAITO PKWY SUITE # 100
PORTLAND, OREGON 97209
TEL. 503.227.7562 FAX 503.227.6138

☐ **PROVIDENCE OCCUPATIONAL HEALTH - CLACKAMAS**
15775 S.E. 82nd DRIVE
PORTLAND, OREGON 97015
TEL. 503.656.4666 FAX 503.656.0675

Occ Health rev [illegible] 7/00 PHS Printing Services 215-5556 Fax 215-5558

174558

Providence Occupational Health
Medical Referral Form

Company Name: _____

Employee Name: _____

Physician Services/Procedures

- ☐ Preplacement Exam
- ☐ Preplacement Exam: DOT qualification
- ☐ Preplacement Exam: respirator qualification
- ☐ DOT Exam
- ☐ Respirator Exam
- ☐ Asbestos Exam
- ☐ Medical Surveillance Exam
- ☐ Physical Capacity Screen
- ☐ Audiogram
- ☐ Resting EKG
- ☐ Other exams/services (please specify):

_____

Drug and Alcohol Screens

☐ Federally mandated ☐ Non-fed. mandated

- ☐ Preplacement Drug Screen
- ☐ Random Screen Drug Screen
  - ☐ Suspicion/Cause Drug Screen
  - ☐ Industrial Accident Drug Screen
  - ☐ Treatment Compliance Drug Screen
  - ☐ Other drug screen (please specify):

_____

☐ Federally mandated ☐ Non-fed. mandated

- ☐ Breathalyzer ☐ Blood alcohol

Other Services

- ☐ Injured worker care

Comments: _____

Appointment date and time:

_____

Authorized signature:

_____

Clinic:

☐ Northwest	☐ Clackamas	☐ Tanasbourne	☐ Parkrose
1750 NW Naito Pkwy.	15775 SE 82nd Dr.	1881 NW 185th Ave.	3510 NE 122nd
First floor		Suite 204	Suite 102
(phone) 227-7562	(phone) 656-4666	(phone) 614-0217(phone)	215-6378
(fax) 227-6138	(fax) 656-0675	(fax) 614-0816	(fax) 215-6572

Employer Information:

If your clinic site requires appointments, you may call them directly to arrange a time. Please give this completed Medical Referral Form to the employee/applicant. They should either bring this form with them to the collection facility or fax it to the facility they are being referred to.

Please see the back of this form for additional instructions on drug testing and exams.

Providence | Health System

May 1999

Providence | Health System

174558

Occupational Health

P.O. Box 3338
Portland, Oregon
97208

Tel 503.216.7966
Fax 503.216.2823

Clinic Locations

Clackamas
(503) 656-4666

Northwest
(503) 227-7562

Parkrose
(503) 215-6378

Tanasbourne
(503) 614-0217

Wilsonville
(opening March 2000)

May 10, 2000

Dave Sprando, Chief Safety Officer
Bureau of Fire Rescue and Emergency Services
4800 NE 122nd
Portland, OR 97220

Dear Chief Safety Office Sprando:

Thank you for the opportunity to respond to the City of Portland Bureau of Fire Rescue & Emergency Services; Profession, Technical and Expert Services Request for Proposals for Respirator Medical Evaluations and Employee Certification. Providence Occupational Health accepts all general instructions, terms and conditions contained in the RFP issued April 19, 2000. Our proposal addresses all areas of concern outlined in the RFP.

The persons authorized to represent Providence Occupational Health in negotiations are our Account Manager, Sandy Tingley and Dr. Milt Gavlick, Program Medical Director. I am the representative authorized to sign proposals and contracts for Providence Occupational Health. Sandy Tingley is your main contact for negotiations and is located at 1881 NW 185th Ave., Suite 204 and can be reached at by phone at 215-7961.

We look forward to the opportunity to expand our working relationship with the City of Portland and the Bureau of Fire Rescue & Emergency Services. Please give Sandy a call if you or have questions or would like to set up an interview with our key staff members regarding this proposal.

Sincerely,

Milt Gavlick, M.D.
Providence Occupational Health
Medical Director

ORDINANCE No. 174558

* Authorize agreement with Providence Health System for respiratory evaluations for Fire Bureau employees, not to exceed $25,000. (Ordinance)

The City of Portland ordains:

Section 1. The Council finds:

1. The Bureau of Fire, Rescue & Emergency Services (Fire Bureau) is in need of medical evaluations for all employees to determine their ability to use a respirator as outlined by the Oregon Occupational Health Administration (OR/OHSA).

2. Oregon Occupational Health Administration (OR/OSHA), Statute OAR 437, Division 2 1910.134 (4/98) requires that in any workplace where respirators are necessary to protect the health of the employee or whenever respirators are required by the employer, the employer shall establish and implement a written respiratory protection program with worksite-specific procedures.

3. The Fire Bureau has followed the requirements of City Code Chapter 5.68 in advertising, interviewing respondents, and using a selection committee to award this contract.

NOW, THEREFORE, the Council directs:

a. The Commissioner of Public Utilities and the Auditor are hereby authorized to execute this agreement with Providence Health System in substantially the form set out in Exhibit A, attached to and part of this Ordinance.

Section 2. The Council declares that an emergency exists because medical evaluations must be performed for all employees who are required to wear respirators; therefore, this ordinance shall be in force and effect from and after its passage by the Council.

Passed by Council:

JUN 21 2000

GARY BLACKMER
Auditor of the City of Portland
By: Deputy

883

Agenda No.

ORDINANCE NO. 174558

Title

* Authorize agreement with Providence Health System for respiratory evaluation for Fire Bureau Employees, not to exceed $25,000 (Ordinance)

INTRODUCED BY	DATE FILED: 6/21/2000 JUN 16 2000
COMMISSIONER JIM FRANCESCONI	Gary Blackmer Auditor of the City of Portland By: Britta Olson Deputy For Meeting of: _____ **ACTION TAKEN:**
NOTED BY COMMISSIONER	
Affairs	
Finance and Administration	
Safety	
Utilities JLF / KTG	
Works	
BUREAU APPROVAL	
Bureau: Bureau of Fire, Rescue and Emergency Services	
Prepared by Kathryn Steinberg Date 6/21/00	
Budget Impact Review: _x_ Completed ___ Not Required	
Bureau Head: Fire Chief Robert Wall Tom Feely for RWall	

AGENDA		FOUR-FIFTHS AGENDA	COMMISSIONERS VOTED AS FOLLOWS:		
				YEAS	NAYS
Consent x	Regular	Francesconi	Francesconi	✓	
NOTED BY		Hales	Hales	✓	
City Attorney Frank Hudson		Saltzman	Saltzman	✓	
City Auditor		Sten	Sten	✓	
City Engineer		Katz	Katz	—	—