

Enclosed is the application packet for the Fall 2024 EMT Course which begins on **August 6, 2024** and will be held on the Akron City Hospital Campus. **Please note: Class is limited to 15 students. A minimum of 8 students are required in order to hold a class.**

#1 PRETEST: The fee for this exam is \$25 payable by check or money order to Summa Health EMS. NO CASH ACCEPTED. The fee can be mailed to the EMS Office or delivered in person by contacting the EMS Office (330-375-9514) to schedule time to submit this payment. All applicants are required to take the on-line pretest exam (unless you have already taken and passed the pretest and your scores are on file with the EMS office). After receiving your pretest payment, you will be e-mailed further information regarding the test.

#2 NOTIFICATION: You will be notified by e-mail the results of your pretest; those who receive a passing score will be invited to apply to the EMT Course. Class is limited to applicants who pass the pretest AND submit a completed application packet. ***Incomplete application packets will be returned to the student.***

All accepted applicants are required to take our BLS Course even if you presently hold a current BLS card.

If you are invited (after you pass the pretest) to apply to the EMT Course, the following will be due by 3 p.m. on **July 22, 2024:**

- 1) completed **EMT application form/packet**
- 2) copies of the **required documents**
- 3) **full tuition payment of \$800 by certified check or money order** (see refund policy). NO CASH ACCEPTED.) Please note that financial aid is not available.

Make tuition fee payable to: Summa Health EMS

Mail completed EMT application packet, required documents and tuition payment to:

Jerri Page/EMS
Summa Health System – Akron Campus
141 N Forge Street
PO Box 2090
Akron OH 44309

Hand delivered application packet paperwork will be accepted by appointment only (call ahead) from 7 a.m. – 2:30 p.m.

Further information will be sent to the **accepted** applicants regarding classroom location and parking. EMT course books will be distributed at class. However, **all accepted applicants must pick up a BLS manual between July 30-31 from the Summa EMS office (call ahead).** **Accepted** applicants are also required to complete a fingerprinting/ background check by our Protective Services. Protective Services is open 7 am-3 pm and closed for lunch 11:30 am-12:30 pm. You will need to show your driver's license and provide your vehicle information (license plate number, make/model/color of vehicle you plan to drive/park in a Summa lot).

If you have any questions, please contact Jerri Page at 330-375-9514 or e-mail: pagej@summahealth.org

Dear EMT Applicant:

Thank you for requesting information regarding the career field of an Emergency Medical Technician. This letter is to provide you with general information concerning the education of an EMT. We hope this will assist you in your decision to pursue this as a professional career.

Career Opportunities

Opportunities to be hired on a private ambulance service or in a hospital setting are limited in the Akron area. However, the surrounding communities with volunteer fire departments do hire EMT. An EMT certification may assist you in being hired in some healthcare facilities or as a peace officer. The EMT certification is a prerequisite for the paramedic program.

EMT Course Description

The program is divided into two parts: Didactic and Clinical

Part I consists of 160 hours of classroom time, of which half of the hours are devoted to practical skills. (rev. 1/2022)

Part II is the clinical portion of the course. The Summa EMT Advisory Committee requires 28 hours of clinical time: 12 hours of field experience riding with a local ambulance (TBD by program director), 12 hours total at Akron City Hospital's emergency department and 4 hours at Akron Children's emergency department. During the clinical rotation the EMT student is required to complete a minimum of 10 adult patient assessments, 8 squad patient assessments, and 4 pediatric patient assessments. Summa requires the EMT student to complete the clinical portion of the curriculum before the National Registry Written Exam.

Summa Health System adheres to the Ohio approved EMS curriculum standards. The curriculum is designed to teach the EMT student how to treat a patient based on their physical assessment findings, and signs and symptoms. The EMT is trained to perform basic life support skills (BLS) in the prehospital setting.

Summa offers the EMT program twice a year. The course is approximately 4½ months in duration.

**Classes are held on two (2) weekday evenings:
Akron City Hospital Campus
Tuesdays & Thursdays
6:00 – 10:00 p.m.**

Admission Requirements for EMS Training

1. Are at least 18 years of age and are not attending high school, except those students who are 17 years old provided that the student is enrolled in the 12th and final grade in a secondary program.
NOTE: Must be at least 18 years old in order to take National Registry testing.
2. Have not been convicted of, please guilty to, or had a judicial finding of guilt for any of the following:
 - Fraud or material deception in applying for, or obtaining, a certificate issued in accordance with the Ohio EMS Board
 - A felony
 - A misdemeanor involving moral turpitude
 - A violation of any federal, state, county or municipal narcotics law
 - Any act committed in another state that, if committed in Ohio, would constitute a violation
3. High school graduate or obtained a GED
4. Be physically fit, of good moral character, and motivated to serve
5. Pass a FIT test (to use any type of respirator, filter-mask, etc.)

The prospective student **MUST** submit a copy of the following:

1. High school diploma or GED
2. Valid Ohio's driver's license
3. Immunization records
 - Quantiferon blood test within 6 months of course start date to rule out TB.
 - Current season flu shot (**starting after September 1, 2024**)
 - Two (2) documented doses of MMR vaccine
 - History of Varicella or Varicella titer history of Varicella (Chicken Pox) —can be verbal history —or 2 vaccines or Varicella Titer.
 - Hepatitis B Vaccine series/ blood titers demonstrating immunity or declination statement
 - Tetanus Toxoid or Tetanus/Diphtheria within last 10 years
 - Urine 10-panel drug screen
 - COVID fully vaccinated (highly recommended but not currently required)

A good source of verification is your school immunization records. If you do not have the above documentation, you can obtain the required vaccinations from:

Center for Corporate Health
1860 State Road, Suite C
Cuyahoga Falls OH 44223
Business hours: Monday-Friday 7:30 a.m.–4:30 p.m.
Telephone: 330-940-5770

FEMALES: If there is any possibility that you are pregnant, **DO NOT** receive the MMR vaccination. Have three blood titers (measles, mumps, rubella) drawn to determine your immunity status.

Course Fees

1. Tuition for the EMT Program is \$800 (see refund policy). Tuition fee includes an American Heart Association BLS Provider Course, all textbooks, and a background check. **Tuition must be paid in full when you submit your application packet.** We do not offer an installment plan for this program. Tuition payment alone does **NOT** reserve a place in the course. Payment can be made by **certified check (no personal checks) or money order.** For VISA or MasterCard payment contact Jerri Page in the EMS office to arrange payment. Under no circumstances will cash be accepted for payment. Note that financial aid is not available for this program.
2. You will be provided a stethoscope and a blood pressure cuff.
3. Plan ahead! The EMT student is responsible for the \$104 fee for the National Registry exam, which is required by the Ohio Board of EMS. The National Registry is a two-part exam, a practical skills exam and a computerized written exam. It is recommended that you pay your application fee at the time you complete your online application to take the written portion of the National Registry test. Fees to **retake** the National Registry exam are at the student's own expense.

Refund Policy

1. A 100% refund for applications being withdrawn by course application deadline.
2. A 50% refund for accepted applicants who withdraw after course deadline and/or during the first week of class.
3. **NO REFUNDS AFTER THE FIRST WEEK OF CLASS.**

Check Off List (for applicant's use only)

I am at least 18 years of age or I am 17 years of age and enrolled in the 12th and final grade in a secondary program.

- √
- ☐ yes Completed Application Form
 - ☐ yes A copy of high school diploma or GED
 - ☐ yes A copy of a valid Ohio driver's license
 - ☐ yes Documentation that you have received two MMR vaccinations.
 - ☐ yes Documentation that you have received a current season flu shot (starting **after September 1, 2024**).
 - ☐ yes Quantiferon blood test within 6 months of course start date to rule out TB.
 - ☐ yes Documentation regarding history of Varicella (Chicken Pox) —can be verbal history— or 2 vaccines or Varicella Titer.
 - ☐ yes Hepatitis B Vaccine series/blood titers demonstrating immunity or declination statement
 - ☐ yes Urine 10-panel drug screen (send out test only -not rapid or instant test)
 - ☐ yes Tetanus Toxoid or Tetanus/Diphtheria within last 10 years
 - ☐ yes COVID vaccine (highly recommended but not currently required)
 - ☐ yes FIT tested (in order to use any type of respirator, filter-mask, etc.)
 - ☐ yes Tuition fee of \$800 certified check or money order — no personal checks or cash accepted.
 - ☐ yes **Pick up BLS manual between July 30-31 from the Summa EMS office. During this time you will also need to get your ID badge and background check/fingerprinting done by Protective Services.**

Tuition fee payable to: Summa Health EMS
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Incomplete application packets will be returned to the student.

EMT Course Application Form

Please print full LEGAL nameNAME: _____
first name middle initial last name maiden name

DOB: _____ E-MAIL: _____

ADDRESS: _____ SS# _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ CELL PHONE: (____) _____

PLACE OF EMPLOYMENT: _____

Classes will begin August 6, 2024 and will be held:**Summa Akron City Campus****141 Forge Street, Akron****Tuesdays and Thursdays****6:00 – 10:00 p.m.**

Have you ever been convicted of a felony? [] YES [] NO

Qualifications for a certificate to practice as stated in section 4765-8-01 of the ORC: Section (3):

Have not been convicted of, pleaded guilty to, or had a judicial finding of guilt for any of the following:

- Fraud or material deception in applying for, or obtaining, a certificate issued in accordance with the Ohio EMS Board
- A felony
- A misdemeanor involving moral turpitude
- A violation of any federal, state, county or municipal narcotics law
- Any act committed in another state that, if committed in Ohio, would constitute a violation.

If yes,

explain: _____

AUTHORIZATION AND RELEASE: As an applicant for admission into the educational program at Summa Health System, I hereby authorize Summa to fully and completely investigate my background generally, and, to that end, I further authorize and direct any and all of my past employers, physicians, schools, references and any and all other persons and organizations to answer all questions asked by Summa concerning, as the case may be, my ability, character, reputation, health, grades and previous employment record. I also understand that I will be fingerprinted by Summa's Protective Services and said fingerprints will be submitted to the Bureau of Criminal Identification and/or the Federal Bureau of Investigation for evaluation. I do hereby release all such persons and organizations from any liability or damages whatsoever because of having furnished such information to Summa Health System.

If you are a minor, your parent must also sign.

Signature: _____ Date: _____

* Parent Signature: _____ Date: _____



Summa Health Corporate Health Authorization and Referral Form

Appointment Information (Photo Identification Required)

Appointment Date: _____ Time: _____

Employee Name: _____

Company Name: **EMS STUDENT - STUDENT**

Please check all required services below:

☐ Injury Treatment

☐ Date/Time of Injury: _____

☐ If State-Insured, Provide MCO Name: _____

☐ Physical Examination – Please Specify Below:

☐ Pre-Placement Physical

☐ Return to Work (attach job description)

☐ Annual

☐ Fit for Duty (attach job description)

☐ DOT Pre-Placement

☐ Functional Capacity Evaluation (FCE)

☐ DOT Recertification

☐ T-8 Bus Driver

☐ P.I.T. Evaluation

☐ Pulmonary Function Testing

☐ New Hire

☐ Recertification

☐ Audiometric Screening

☐ Respiratory Clearance

☐ Immunization(s): _____

☐ Exam

☐ Fit Test

☐ OSHA Medical Surveillance

☐ Hearing Test

☐ Other Screening/Testing: _____

☐ Substance Abuse Testing

Testing Type:

Reason for Testing (Required):

☒ Urine Drug Screen

☐ Pre-placement

☐ DOT – Agency (circle):

☐ Reasonable Suspicion or Cause

FMCSA FRA FTA FAA Other: _____

☐ Random

☐ Non DOT

☐ Post-accident/Injury

☐ Rapid

☐ Return to Work

☐ Breath Alcohol Screen

☐ Follow-up

☐ Hair Drug Screen

☒ Other: _____

☐ Saliva Drug Screen

☐ Specimen Collection ONLY

☐ Urine

☐ Hair

Services Authorized By:

Company Representative: _____

Title: _____

Phone Number: _____

Comment/Special Instructions: **SELF PAY SUMMA EMS STUDENT DRUG SCREEN~\$45**

Please Give This To Receptionist Upon Arrival

Summa Health Corporate Health Services Convenient hours are available at five locations

Prevention

- Audiograms
- Ergonomic Assessments of Work Areas
- Health Risk Assessments
- Hearing Conservation Programs
- Immunizations (travel health and workplace)
- On-Site Safety Risk Assessments
- Respirator Fit Testing
- Routine Laboratory Testing
- Tuberculosis (TB) Screening
- Titmus Vision Screening

Evaluation

- ADA Assessments
- Annual Physical Exams
- Department of Transportation (DOT) Exams
- Executive Physicals
- EKGs
- Fitness for Duty
- Functional Capacity Evaluations (FCE)
- HAZMAT Exams
- OSHA Required Exams
- Police/Fire Pension Fund Exams
- Pre-Employment Physical Exams
- Return to Work Evaluations
- Pulmonary Function Screening
- Surveillance Screening/Exams
- T8 Bus Driver Exams
- X-Rays

On Site/ Mobile Services

- Mobile/On-Site Testing
- On-Site Nursing Services

Rehabilitation

- Occupational Therapy
- Physical Therapy
- Transitional Work
- Work Conditioning

Substance Abuse

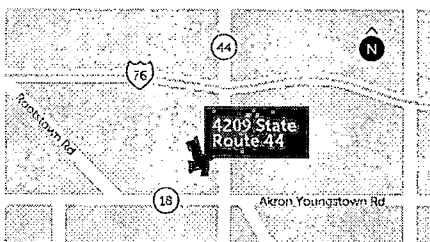
- Breath Alcohol Testing
- DOT and Non-DOT Drug Testing
- Drug-Free Workplace Program Management
- Employee and Supervisor Training
- MRO Services

Wellness Programs

- Health Risk Appraisals
- Health Screenings (blood pressure, cholesterol/lipids, glucose, PSA)
- Wellness Educational Programs

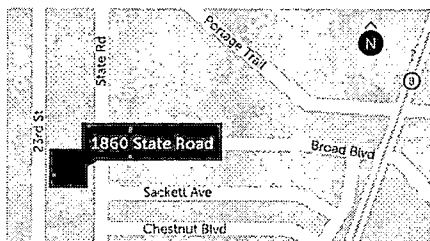
Work Capacity Services

- Modified Duty Recommendations
- Transitional Work Programs
- Work Conditioning Programs



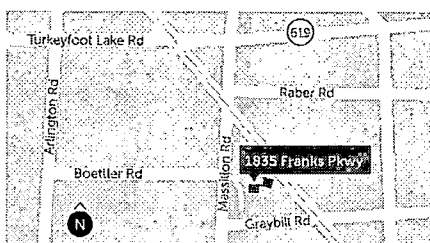
Summa Health Rootstown Medical Center
4209 State Route 44, Suite 120
Rootstown, OH 44272

- Phone: 330.325.7237
- Fax: 330.325.7238
- Hours: Monday – Friday
7:30 a.m. – 4:00 p.m.



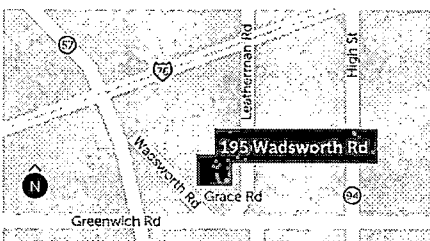
Summa Health Cuyahoga Falls Medical Center
1860 State Road, Suite C
Cuyahoga Falls, OH 44223

- Phone: 330.940.5770
- Fax: 330.940.5771
- Hours: Monday – Friday
7:30 a.m. – 4:00 p.m.



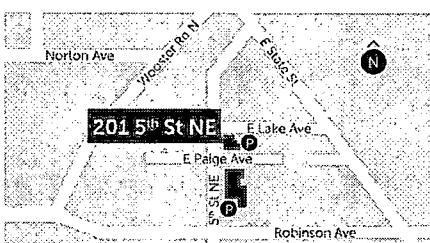
Summa Health Green Medical Center
Heritage Crossings of Green
1825 Franks Parkway
Door 2
Uniontown, OH 44685

- Phone: 330.899.5540
- Fax: 330.899.5543
- Hours: Monday – Friday
7:30 a.m. – 4:00 p.m.



Summa Health Wadsworth-Rittman Medical Center
(Emergency Department Entrance)
195 Wadsworth Road
Wadsworth, OH 44281

- Phone: 330.331.1510
- Fax: 330.331.1923
- Hours: Monday – Friday
7:30 a.m. – 4:00 p.m.



Summa Health Tuscora Park Medical Building
(Next to Summa Health System — Barberton Campus)
201 Fifth Street NE, Suite 11
Barberton, OH 44203

- Phone: 330.615.5300
- Fax: 330.615.5310
- Hours: Monday – Friday
7:30 a.m. – 4:00 p.m.

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

(OSHA Standards - 29 CFR; Appendix C to Sec. 1910.134)

Employer: _____

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

To the employee:

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. 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. (Mandatory)

The following information must be provided by every employee who has been selected to use any type of respirator. (please print)

I certify that the information I am providing on this form is true to the best of my knowledge.

Signature: _____ **Date:** _____

Name : _____ **SS#:** _____ **Sex:** ☐ M ☐ F

DOB: _____ **Age:** _____

Height: _____ **Weight:** _____ **Job Title:** _____
(feet) (inches)

A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____

The best time to phone you at this number: _____

Has your employer told you how to contact the health care professional who reviews this questionnaire? ☐ Yes ☐ No

Check the type of respirator you will use (you can check more than one category):

☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

☐ Other type (e.g., half or full-face piece type, powered-air purifying (PAPR), supplied-air, self-contained breathing apparatus (SCBA)).

Have you worn a respirator?

If "yes", what type(s): ☐ Yes ☐ No

Part A. Section 2. (Mandatory)

Name: _____

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator.

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 have 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 or 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 breath 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 problems?
- 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 problems that you have 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
 - d. In the past 2 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

Part A. Section 2. (Mandatory - continued)

Name: _____

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

- a. Breathing or lung problems
- b. Heart trouble
- c. Blood pressure
- d. Seizures (fits)

☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No

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

- a. Eye irritation
- b. Skin allergies or rashes
- c. Anxiety
- d. General weakness or fatigue
- e. Any other problem that interferes with your use of a respirator

☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No

9. Would you like to speak with the reviewing health care professional about your answers to this questionnaire?

☐ Yes ☐ No

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
- b. Wear glasses
- c. Color blind
- d. Any other eye or vision problem

☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ 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?

- a. Difficulty hearing
- b. Wear a hearing aid
- c. Any other hearing or ear problem

☐ Yes ☐ No
☐ Yes ☐ No
☐ 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
- b. Back pain
- c. Difficulty fully moving your arms and legs
- d. Pain or stiffness when you lean forward or backward at the waist
- e. Difficulty fully moving your head up or down
- f. Difficulty fully moving your head side to side
- g. Difficulty bending at your knees
- h. Difficulty squatting to the ground
- i. Climbing a flight of stairs or a ladder carrying more than 25 lbs
- j. Any other muscle or skeletal problem that interferes with using a respirator

☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No

Comments:

Name: _____

Part B. Discretionary/Voluntary Questions

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 are 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?

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 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Silica (e.g., sandblasting) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Tungsten/cobalt (e.g., grinding or welding this material) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Beryllium | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Aluminum | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Coal (e.g., mining) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Iron | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Tin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Dusty environments | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Any other hazardous exposures | <input type="checkbox"/> Yes <input type="checkbox"/> 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)?

If "Yes," name the medications if you know them: ☐ Yes ☐ No

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

- | | |
|--------------------------------|--|
| a. HEPA filters | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Canisters (e.g., gas masks) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Cartridges | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Part B. (Discretionary/Voluntary questions - continued)

Name: _____

11. How often are you expected to use the respirator(s)? (check all answers that apply to you)

- | | |
|-----------------------------------|--|
| a. Escape only (no rescue duties) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Emergency rescue only | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Less than 5 hrs. per week | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Less than 2 hrs. per day | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. 2 to 4 hrs. per day | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. over 4 hrs. per day | <input type="checkbox"/> Yes <input type="checkbox"/> No |

12. During the period you are using your 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 are using your 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 will be doing while using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you are 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 will be exposed to when using your respirator(s):

Name of the first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of any other toxic substances that you will be exposed to while using your respirator(s):

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

Provider: _____

Date: _____