College of Staten Island
The City University of New York

Department of Nursing
Respiratory Protection Evaluation Form

Part 1: This section should be completed by the nursing student to use respiratory protection during the course of work activities and PRIOR to the medical evaluation.

Name_____ **Job Title** Nursing Student
Department Nursing **Cell Phone#** N/A

Part 2: This section should be completed by the employee's department PRIOR to the medical evaluation.

Department Supervisor Nursing **Date**_____
Type of respirator to be used (half-face, full-face, PAPR, etc.): Half-face N95
Description of work effort (circle one): **Low** **Moderate** **Strenuous**
Type of work to be performed with respirator use: Clinical/All patient care
Special environmental conditions: None known
Names of each toxic substance during exposure/work: None known
Estimated maximum exposure level during work: 6-8 hour clinical shift in hospital or ambulatory setting
Duration of exposure per shift: 6-8 hour clinical shift in hospital or ambulatory setting

Part 3: This section should be completed by the health care provider after the medical evaluation.

Health Care Provider:_____ **Phone#:**_____
Name of Examining Health Care Provider (print):_____
Signature of Examining Health Care Provider:_____

Student is (circle one): **without restrictions** **physically able to wear a respirator.**
with restrictions **physically able to wear a respirator.**
Describe restrictions_____

Student **is not** **physically able to wear a respirator.**

Part 4: This section should be completed by the student's department after training and fit- testing.

Department Supervisor (print and sign):
_____

Student **was** **was not** **trained in respiratory protection (circle one).**
was **was not** **fit-tested with respirator (circle one).**

Respirator Specifications:
Make/Model_____ **Size (S/M/L)**_____
Filter Type(s)_____