University of Massachusetts Medical School
Respirator Fitness Determination

Name: ________________________________________________________________________________

Graduating Class: _________________________________________ Date of Birth _____/____/______

Questionnaire to determine fitness to wear a NIOSH approved respirator. Please check each item YES or NO. If you check YES, please provide an explanation. All questions must be answered.
Any questions can be addressed to Student Health Services @ studenthealth@ummhc.org

1. Have you worn a respirator before? _____ No _____ Yes
   (what type/for what purpose?) ______________________________

2. Have you had problems wearing a respirator? _____ No _____ Yes    Explain__________________

3. Do you have claustrophobia or anxiety problems that would make wearing a mask difficult for you? ____No____Yes

4. Do you have a beard or mustache? _____ No _____Yes    Explain__________________

5. Do you have problems with your sense of smell? _____ No ____Yes    Explain__________________

6. Do you have skin allergies? Other allergies? ____ No  ____ Yes    Explain__________________

7. Do have any heart problems? (Angina, heart failure)? ____ No ____ Yes  Are you symptomatic…edema, shortness of breath. ______

8. Do you have any lung disease (chronic cough, emphysema, asthma, infections, bronchitis)?____No___Yes
   Are you symptomatic _____  Are you well controlled on medication? ______

9. Do you smoke? _____ No  _____ Yes  How many packs per day?____ How many years?_____
   Are you symptomatic with respiratory problems?____

10. Do you have seizures? _____ No  _____ Yes    Are you well controlled on medication?_____

11. What prescription medications are you taking?
    ____________________  ____________________  ____________________  ____________________

   Student Signature: __________________________________ Date:___________________________

Return the completed form to: STUDENTHEALTH@UMASSMEMORIAL.ORG

Student Health Services Use Only:
   _____ Approved for PAPR
   _____ Approved for tuberculosis respirator N-95 Mask
   _____ Awaiting further data, on medical hold
   _____ Not approved for respirator use

Revised 03/13/23

Date:______________   Ext. ______________