

RESPIRATORY PROTECTION MEDICAL EVALUATION QUESTIONNAIRE

OPOS 13R (11/11)
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INSTRUCTIONS: Candidate, please complete sections A and B — type or print clearly.

Evaluations are based on the candidate's ability to use the following respirators:

- MSA Advantage 1000 Respirator
- MSA Advantage 3000 Respirator
- 3M 8210/8210 Plus Cup Style
- Sperian One Fit, Flat Fold, Health

SECTION A					
NAME (Last, First, Middle)					SSN (Last 6)
HEIGHT	WEIGHT	GENDER		DATE OF BIRTH	AGE
Feet Inches	Pounds	Male <input type="checkbox"/>	Female <input type="checkbox"/>		
DAYTIME PHONE (Include area code)			Have you ever used a respirator?		TODAY'S DATE
			Yes <input type="checkbox"/>	No <input type="checkbox"/>	

SECTION B

Read the question and check the appropriate box.	YES	NO
1. Do you <i>currently</i> smoke tobacco, or have you smoked tobacco in the last month?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had any of the following conditions:		
a. Seizures (fits)	<input type="checkbox"/>	<input type="checkbox"/>
b. Diabetes (sugar disease)	<input type="checkbox"/>	<input type="checkbox"/>
c. Allergic reactions that interfere with your breathing	<input type="checkbox"/>	<input type="checkbox"/>
d. Claustrophobia (fear of closed-in places)	<input type="checkbox"/>	<input type="checkbox"/>
e. Trouble smelling odors	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had any of the following pulmonary or lung problems:		
a. Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
c. Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
d. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
e. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
f. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
g. Silicosis	<input type="checkbox"/>	<input type="checkbox"/>
h. Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>
i. Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>
j. Broken ribs	<input type="checkbox"/>	<input type="checkbox"/>
k. Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/>
l. Any other lung problem that you've been told about? If yes, describe:	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you currently have any of the following symptoms of pulmonary or lung illness:		
a. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/>	<input type="checkbox"/>
(Question 4 continued)		
c. Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
d. Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
e. Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>
f. Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
g. Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>
h. Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>
i. Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/>
j. Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/>
k. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
l. Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
m. Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/>
n. Any other symptoms that you think may be related to lung problem? If yes, describe:	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had any of the following cardiovascular or heart problems:		
a. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
b. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
c. Angina	<input type="checkbox"/>	<input type="checkbox"/>
d. Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
e. Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/>	<input type="checkbox"/>
f. Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/>	<input type="checkbox"/>
g. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
h. Any other heart problem that you've been told about? If yes, describe:	<input type="checkbox"/>	<input type="checkbox"/>

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6. Have you ever had any of the following cardiovascular or heart symptoms:	YES	NO
a. Frequent pain or tightness in your chest	<input type="checkbox"/>	<input type="checkbox"/>
b. Pain or tightness in your chest during activity	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain or tightness in your chest that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past two years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/>	<input type="checkbox"/>
e. Heartburn or indigestion that is not related to eating	<input type="checkbox"/>	<input type="checkbox"/>
f. Any other symptoms that you think may be related to heart or circulation problems. If yes, describe:	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you currently take medication for any of the following problems:		
a. Breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
b. Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
c. Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
d. Seizures (fits)	<input type="checkbox"/>	<input type="checkbox"/>
8. If you have ever used a respirator, answer the following questions. If you have never used a respirator, proceed to question 9. Type(s) of respirators used: _____		
Have you ever had any of the following problems associated with the use of a respirator:		
a. Eye irritation	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin allergies or rashes	<input type="checkbox"/>	<input type="checkbox"/>
c. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
d. General weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>
e. Any other problem that interfered with the use of a respirator. If yes, describe:	<input type="checkbox"/>	<input type="checkbox"/>
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever lost vision in either eye (temporarily or permanently)?	<input type="checkbox"/>	<input type="checkbox"/>

11. Do you currently have any of the following vision problems:	YES	NO
a. Wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
b. Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>
c. Color blind	<input type="checkbox"/>	<input type="checkbox"/>
d. Any other eye or vision problem. If yes, describe:	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever had an injury to your ears, including a broken eardrum	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you currently have any of the following hearing problems:		
a. Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>
b. Wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>
c. Any other hearing or ear problem. If yes, describe:	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had a back injury?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you currently have any of the following musculoskeletal problems:		
a. Weakness in any of your arms, hands, legs, or feet	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain	<input type="checkbox"/>	<input type="checkbox"/>
c. Difficulty fully moving your arms and legs	<input type="checkbox"/>	<input type="checkbox"/>
d. Pain and stiffness when you lean forward or backward at the waist	<input type="checkbox"/>	<input type="checkbox"/>
e. Difficulty fully moving your head up or down	<input type="checkbox"/>	<input type="checkbox"/>
f. Difficulty fully moving your head side to side	<input type="checkbox"/>	<input type="checkbox"/>
g. Difficulty bending at your knees	<input type="checkbox"/>	<input type="checkbox"/>
h. Difficulty squatting to the ground	<input type="checkbox"/>	<input type="checkbox"/>
i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 pounds	<input type="checkbox"/>	<input type="checkbox"/>
j. Any other muscle or skeletal problem that interferes with using a respirator. If yes, describe:	<input type="checkbox"/>	<input type="checkbox"/>

PRIVACY NOTICE

Agency Responsible for Maintenance: California Department of Corrections and Rehabilitation (CDCR)
Office of Peace Officer Selection, 9838 Old Placerville Road, Suite B, Sacramento, CA 95827

Authority and Purpose: Government Code Sections 18934 and 1031. The information you furnish will be used to determine if you have any medical or emotional condition which would limit your ability to perform the essential functions of the position.

Providing Information: Accepting employment as a peace officer is voluntary. If you choose to accept employment, Government Code Section 1031 requires a medical evaluation before appointment.

Access: Your medical records become confidential information and the property of the CDCR. Only authorized personnel directly involved in the selection process will be allowed access.