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| --- | --- | --- | --- | --- | --- |
| **Name** |  | **Date of birth** | **\_\_\_\_/\_\_\_/\_\_\_\_\_** | **Phone** | ( ) |
| **Address** |  | **City & State** |  | **SBUH**  **ID#** |  |
| **Supervisor**  **Name** |  | **Depart-ment** |  | **Job Title** |  |

**Can you read/understand English? □ 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. (Mandatory)**  Every employee who has been selected to use any type of respirator must provide the following information. (Please print) | |
| 1. | Today’s date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| 2. | Your age (to nearest year):\_\_\_\_\_\_\_\_\_\_ |
| 3. | Sex: □ Male □ Female |
| 4. | Your height: \_\_\_\_\_\_ft. \_\_\_\_\_in. |
| 5. | Your weight: \_\_\_\_\_\_ lbs. |
| 6. | A phone number where you can be reached by the health care professional who reviews this questionnaire: |
|  | ( ) - |
| 7. | The best time to phone you at this number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Part A. Section 2. (Mandatory)** | | | |
|  | **YES** | **NO** |  |
| 1. | □ | □ | **Do you currently smoke tobacco, or have you smoked tobacco in the last month?** If yes, how many cigarettes per day and how many years:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |
| 2. | □ | □ | **Have you ever had any of the following conditions**? If yes, please provide dates and details |
|  | □ | □ | **Seizures**: If yes, please note below date of last seizure and current treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | □ | □ | **Diabetes**: if yes, please note recent Hgb A1c and/or usual blood sugar levels, current diabetes medications and whether you have had any low blood sugars requiring medical assistance in past year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | □ | □ | **Allergic reactions that interfere with your breathing**: If yes, specify dates, what happened, and any relation to job: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | □ | □ | **Claustrophobia (fear of closed-in places)**: If yes, specify when/what happened and if you feel this may impact your ability to wear respirator or perform certain job duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | □ | □ | **Trouble smelling odors**: please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | | |
| 3. | **Have you ever had any of the following pulmonary or lung problems?** If yes, please provide  dates and details | | |
|  | □ | □ | **Asbestosis**: please provide dates/details: |
|  | □ | □ | **Asthma** (if current condition, please state your triggers, current treatment, if you have required hospital stays/ER visits due to asthma and dates; if resolved childhood asthma please state \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | **YES**  □ | **NO**  □ | **(continued)**  **Chronic bronchitis**: please provide dates/details: |
|  | □ | □ | **Emphysema**: please provide dates/details: |
|  | □ | □ | **Pneumonia**: please provide dates/details: |
|  | □ | □ | **Tuberculosis**: please provide dates, treatment: |
|  | □ | □ | **Silicosis**: please provide dates/details: |
|  | □ | □ | **Pneumothorax (collapsed lung):** please provide dates/details |
|  | □ | □ | **Lung cancer**: please provide dates/treatment: |
|  | □ | □ | **Broken ribs**: please provide dates/details: |
|  | □ | □ | **Any chest injuries or surgeries** please provide dates/details: |
|  | □ | □ | **Any other lung problem that you’ve been told about**: please provide dates/details: |
|  |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 4. | **Do you currently have any of the following symptoms of pulmonary or lung illness?** | | |
|  | □ | □ | Shortness of breath |
|  | □ | □ | Shortness of breath when walking fast on level ground or walking up a slight hill or incline |
|  | □ | □ | Shortness of breath when walking with other people at an ordinary pace on level ground |
|  | □ | □ | Have to stop for breath when walking at your own pace on level ground |
|  | □ | □ | Shortness of breath when washing or dressing yourself |
|  | □ | □ | Shortness of breath that interferes with your job |
|  | □ | □ | Coughing that produces phlegm (thick sputum) |
|  | □ | □ | Coughing that wakes you early in the morning |
|  | □ | □ | Coughing that occurs mostly when you are lying down |
|  | □ | □ | Coughing up blood in the last month |
|  | □ | □ | Wheezing |
|  | □ | □ | Wheezing that interferes with your job |
|  | □ | □ | Chest pain when you breathe deeply |
|  | □ | □ | Any other symptoms that you think may be related to lung problems  **If yes to any of the above please provide details**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |
| 5. | **Have you ever had any of the following cardiovascular or heart problems?** | | |
|  | □ | □ | **Heart attack**: please provide date, treatment and any current activity restrictions: |
|  | □ | □ | **Stroke**: please provide dates, treatment and any current activity restrictions: |
|  | □ | □ | **Angina**: please provide date, treatment and any current activity restrictions: |
|  | □ | □ | **Heart failure:** please provide dates, treatment and any current activity restrictions: |
|  | □ | □ | **Swelling in your legs or feet (not caused by walking):** please provide dates, treatment and any current activity restrictions: |
|  | □ | □ | **Heart arrhythmia** (heart beating irregularly): please provide dates, treatment and any current activity restrictions: |
|  | □ | □ | **High blood pressure:** please provide dates, treatment and your usual blood pressure readings: |
|  | □ | □ | **Any other heart problem that you’ve been told about**: please describe: |
|  |  |  |  |
| 6. | **Have you ever had any of the following cardiovascular or heart symptoms?** | | |
|  | □ | □ | Frequent pain or tightness in your chest |
|  | □ | □ | Pain or tightness in your chest during physical activity |
|  | □ | □ | Pain or tightness in your chest that interferes with your job |
|  | □ | □ | In the past two years, have you noticed your heart skipping or missing a beat |
|  | □ | □ | Heartburn or indigestion that is not related to eating |
|  | □ | □ | Any other symptoms that you think may be related to heart or circulation problem  **If yes to any of the above please provide dates and details:** |
|  |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 7. | **YES NO**  **Do you currently take medication for any of the following problems?** | | |
|  | □ | □ | Breathing or lung problems: please list medications |
|  | □ | □ | Heart trouble: please list medications: |
|  | □ | □ | Blood pressure: please list medications: |
|  | □ | □ | Seizures (fits): please list medications: |
|  |  |  |  |
| 8. | **If you have used a respirator, have you ever had any of the following problems?**  *(If you have never used a respirator, check no and go to question 9)* | | |
|  | □ | □ | Eye irritation |
|  | □ | □ | Skin allergies or rashes |
|  | □ | □ | Anxiety |
|  | □ | □ | General weakness or fatigue |
|  | □ | □ | Any other problem that interferes with your use of a respirator  **If yes to any of the above, please provide dates and details. Have you successfully used a respirator since the problem occurred?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |
| 9. | □ | □ | **Would you like to talk to the health care professional who will review this questionnaire about the answers you provided?** (i.e. do you have questions/concerns to discuss with provider?) |

**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).**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Part A. Section 2. (Continued)** | | | | | | | | | |
|  | | | | **YES** | | | **NO** | | |  |
| 10. | | | □ | | | □ | | | **Have you ever lost vision in either eye (temporarily or permanently)?** Please provide date and details: | |
|  | | |  | | | | | | | |
| 11. | | | **Do you currently have any of the following vision problems?** | | | | | | | |
|  | | | □ | | | □ | | | Wear contact lenses | |
|  | | | □ | | | □ | | | Wear glasses | |
|  | | | □ | | | □ | | | Color blind | |
|  | | | □ | | | □ | | | Any other eye or vision problem: please describe | |
|  | | |  | | |  | | |  | |
| 12. | | | □ | | | □ | | | **Have you ever had an injury to your ears, including a broken eardrum?** Please provide dates/details: | |
|  | | |  | | | | | | | |
| 13. | | | **Do you currently have any of the following hearing problems?** | | | | | | | |
|  | | | □ | | | □ | | | Difficulty hearing: please describe: | |
|  | | | □ | | | □ | | | Wear a hearing aid | |
|  | | | □ | | | □ | | | Any other hearing or ear problem: please describe: | |
|  | | |  | | |  | | |  | |
| 14. | | | □ | | | □ | | | **Have you ever had a back injury?** If yes, please provide dates and details. Please note any current activity limitations: | |
|  | | |  | | | | | | | |
| 15. | | | **Do you currently have any of the following musculoskeletal problems?** If yes, please describe | | | | | | | |
|  | | | □ | | | □ | | | Weakness in any of your arms, hands, legs, or feet | |
|  | | | □ | | | □ | | | Back pain | |
|  | | | □ | | | □ | | | Difficulty fully moving your arms and legs | |
|  | | | □ | | | □ | | | Pain or stiffness when you lean forward or backward at the waist | |
|  | | | □ | | | □ | | | Difficulty fully moving your head up or down | |
|  | | | □ | | | □ | | | Difficulty fully moving your head side to side | |
|  | | | □ | | | □ | | | Difficulty bending at your knees | |
|  | | | □ | | | □ | | | Difficulty squatting to the ground | |
|  | | | □ | | | □ | | | Climbing a flight of stairs or a ladder carrying more than 25 lbs. | |
|  | | | □ | | | □ | | | Any other muscle or skeletal problem that interferes with using a respirator  **If yes to any of the above, describe**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Part B** | | | | | | | | | | |
|  | | **YES** | | | **NO** | | |  | | |
| 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? | | |
|  | | □ | | | □ | | | If ‘‘yes,’’ do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you’re working under these conditions? | | |
| 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? | | | | | | | | |
|  | | □ | | | □ | | | Asbestos | | |
|  | | □ | | | □ | | | Silica (e.g., in sandblasting) | | |
|  | | □ | | | □ | | | Tungsten/cobalt (e.g., grinding or welding this material) | | |
|  | | □ | | | □ | | | Beryllium | | |
|  | | □ | | | □ | | | Aluminum | | |
|  | | □ | | | □ | | | Coal (for example, mining) | | |
|  | | □ | | | □ | | | Iron | | |
|  | | □ | | | □ | | | Tin | | |
|  | | □ | | | □ | | | Dusty environments | | |
|  | | □ | | | □ | | | Any other hazardous exposures | | |
|  | | | | | | | | 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  | |  | | |  | | |  | | |
|  | | **YES** | | | **NO** | | |  | | |
| 7. | | □ | | | □ | | | Have you been in the military services? | | |
|  | | □ | | | □ | | | If ‘‘yes,’’ were you exposed to biological or chemical agents (either in training or combat?) | | |
| 8. | | □ | | | □ | | | Have you ever worked on a HAZMAT team? | | |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 10 | | □ | | | □ | | | Will you be using any of the following items with your respirator(s)? | | |
|  | | □ | | | □ | | | HEPA Filters | | |
|  | | □ | | | □ | | | Canisters (for example, gas masks) | | |
|  | | □ | | | □ | | | Cartridges | | |
|  | |  | | | | | | | | |
| 11 | | How often are you expected to use the respirator(s) (Check ‘‘yes’’ or ‘‘no’’ for all answers that apply to you) | | | | | | | | |
|  | | □ | | | □ | | | Escape only (no rescue) | | |
|  | | □ | | | □ | | | Emergency rescue only \_\_\_\_ hours per week \_\_\_\_ hours per day | | |
|  | |  | | | | | | | | |
| 12 | | During the period you are using the respirator(s), is your work effort: | | | | | | | | |
|  | |  | | | | | | | | |
|  | | Light  □ | | | | | | 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. | | |
|  | | Moderate  □ | | | | | | 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. | | |
|  | | Heavy  □ | | | | | | 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.). | | |
|  | |  | | |  | | |  | | |
|  | | **YES** | | | **NO** | | |  | | |
| 13 | | □ | | | □ | | | Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator? | | |
|  | |  | | |  | | | If ‘‘yes,’’ describe this protective clothing and/or equipment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 14 | | □ | | | □ | | | Will you be working under hot conditions (temperature exceeding 77° F)? | | |
| 15 | | □ | | | □ | | | Will you be working under humid conditions? | | |
|  | |  | | | | | | | | |
| 16 | | Describe the work you’ll be doing while you are 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 | | Name the toxic substances you will be exposed to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  | |  | | | | | | | | |
| 19 | | Describe any special responsibilities you’ll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |

**FOR OFFICE USE ONLY**

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| --- | --- |
| **Reviewing Provider Name and Signature:** | **Date:** |

Revised 11/22/2020