RESPIRATOR MEDICAL QUESTIONNAIRE FAQs

COMPLETING YOUR MQ

Q: Do I need to answer all the questions on the MQ?

A: The e-mail you received will have identified which training you are being considered for. Please use the chart below to determine which questions you should answer on your MQ.

- To attend Respiratory Protection Training, you will need either Half-Mask or Full-Mask approval.
- To attend Remediating Contaminated Buildings Training, you must have Full-Mask approval.

Half-Mask Approval		Full-Mask Approval	
	Answer all questions in sections 1-8	Answer all questions in sections 1-14	
	If you answer *'yes'* to any questions in sections 2-8, a Healthcare Provider must sign your MQ.	If you answer *'yes'* to any questions in sections 2-14, a Healthcare Provider must sign your MQ.	
	**Some volunteers who only need half-mask approval seek full-mask approval so that they are prepared to accept future safety training invitations that may require the additional approval.*	**If you answer 'yes' to wearing glasses or contacts on question 10, a Healthcare Provider must sign your MQ.*	

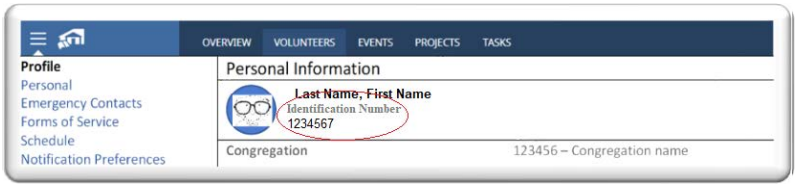
Q: What should I do if I am having trouble filling out the form electronically?

A: We find it best to use a computer to fill out your MQ … NOT a cell phone or tablet. If you are still having difficulty, you can print out the MQ and complete it using a pen and paper.

Q: Where can I find my Builder Assistant/Indentification Number?

A: Follow these steps:

1. Log into Builder Assistant.
2. In the top right-hand corner, click on your picture.
3. Click on 'My Profile'.
4. Your 'Builder Assistant Number' is the 'Identification Number' listed under your name.



HEALTHCARE PROVIDER

Q: What type of doctor can authorize my MQ?

A: Some examples of healthcare providers that are authorized to sign your Questionnaire are: your personal Physician, a Physician's Assistant, or a Nurse Practitioner. A dentist or optometrist (eye doctor) would not meet this qualification.

Q: What if I do not have a regular doctor?

A: You may be able to consult with a medical professional at a walk-in clinic, Urgent Care, public health center, or family care clinic.

Q: What if I am not comfortable going to my doctor during COVID?

A: You may be able to consult with your Healthcare Provider virtually or by phone. In such cases, they may be willing to accept an electronic copy of the Questionnaire or allow you to drop it off at their office for completion.

Q: What if I can't get an appointment with my doctor right away?

A: We understand that it may be difficult to get an appointment with your doctor. Safety training classes are routinely scheduled so please make your appointment as soon as is possible.

Q: What boxes should my doctor check so that I can attend Respiratory Protection Training?

A: If medically cleared, please have your doctor check the first two boxes ('Particulate Respirators' and 'Combination Respirators') in the Healthcare Provider section. Please also confirm that your doctor signs and dates the form where indicated.

SUBMITTING YOUR MQ

Q: How do I submit my MQ?

A: Follow these steps:

1. Save the completed 4-page MQ as a single PDF.
2. Attach that file to an email that you compose from your own personal JWPUB email address. Send that email to MichellM25@jwpub.org.
   **If you do not have a JWPUB email address, please send your MQ to InboxLDCVSGZone3.us@bethel.jw.org.*

Q: What if I am having problems submitting my MQ electronically?

A: You can print your completed MQ and mail a copy of the form to: Shelly McLeod, 1051 Winding Way NW, Supply, NC 28462.
**Please keep a copy for your records in case your MQ gets lost or damaged in the USPS mail.*

RESPIRATOR QUESTIONNAIRE

NOTE: This questionnaire should be used to determine whether or not you have a physical condition that would affect your ability to safely wear a respirator.

Personal Information and History

To be completed by the potential respirator user. (Please print neatly.)

Name of Volunteer:	Ronald Gartrell		**Gender:**	☑ Male	☐ Female
Height:	6 ft 0 in/cm	**Weight:**	220 lbs/kg	**DOB:**	05 / 07 / 1958
Builder Assistant #:	27688393				

1.	**Does your current form of employment require you to regularly use a respirator?**	☐ Yes	☑ No
2.	**Do you have a history of any condition listed below?**		
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 spaces)	☐ Yes	☑ No
e.	Trouble smelling odors	☐ Yes	☑ No
If you answered "Yes" to any of the questions above, please provide further details:			
3.	**Do you have a history of the following?**		
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.	Other chest injuries or surgeries	☐ Yes	☑ No
If you answered "Yes" to any of the questions above, please provide further details:			

QUESTIONNAIRE SUBMITTED BY:	Ronald Gartrell

4. Do you currently have any of the following?		
a. Shortness of breath	☐ Yes	☑ No
b. Shortness of breath when walking quickly on level ground, or when walking up a slight hill or incline	☐ Yes	☑ No
c. Shortness of breath when walking with other people at an ordinary pace on level ground	☐ Yes	☑ No
d. The need 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 wakes you early in the morning	☐ Yes	☑ No
h. Coughing that produces phlegm (thick sputum)	☐ Yes	☑ No
i. Coughing that occurs mostly when you are lying down	☐ Yes	☑ No
j. Coughing up blood within the last month	☐ Yes	☑ No
k. Wheezing	☐ Yes	☑ No
l. Chest pain when you breathe deeply	☐ Yes	☑ No
m. Other symptoms that you think may be related to lung problems	☐ Yes	☑ No
If you answered "Yes" to any of the questions above, please provide further details:		

5. Do you have a history of the following?		
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. Other heart problems	☐ Yes	☑ No
If you answered "Yes" to any of the questions above, please provide further details:		

6. Do you have a history of the following?		
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 which interferes with your job	☐ Yes	☑ No
d. Heart skipping or missing a beat (within the past two years)	☐ Yes	☑ No
e. Heartburn or indigestion that is not related to eating	☐ Yes	☑ No
f. Other symptoms that you think may be related to a heart or circulation problem	☐ Yes	☑ No
If you answered "Yes" to any of the questions above, please provide further details:		

QUESTIONNAIRE SUBMITTED BY:	Ronald Gartrell

7. Do you currently take medication for any of the following conditions?		
a. Breathing or lung problems	☐ Yes	☑ No
b. Heart trouble	☐ Yes	☑ No
c. Blood pressure	☐ Yes	☑ No
d. Seizures (fits)	☐ Yes	☑ No

If you answered "Yes", please provide the name of the medication:	

If you have never used a respirator, check the following box.	☐ I have never used a respirator

8. Do you have a history of the following during or after the use of a respirator?		
a. Eye irritation	☐ Yes	☑ No
b. Skin allergies or rashes	☐ Yes	☑ No
c. Anxiety	☐ Yes	☑ No
d. General weakness or fatigue	☐ Yes	☑ No
e. Frequent pain or tightness in your chest	☐ Yes	☑ No
f. Pain or tightness in your chest during physical activity	☐ Yes	☑ No
g. Pain or tightness in your chest that interferes with your job	☐ Yes	☑ No
h. Heart skipping or missing a beat (within the past two years)	☐ Yes	☑ No
i. Other problem that interferes with your use of a respirator (please indicate)		

Questions 9-14 below must be answered by every volunteer who has been selected to use either a full mask respirator or a self-contained breathing apparatus (SCBA). For volunteers who have been selected to use other types of respirators, answering these questions is voluntary.

9. Have you ever lost vision in either eye (temporarily or permanently)?	☐ Yes	☑ No

10. Do you currently have any of the following vision problems?		
a. Wear contact lenses	☐ Yes	☑ No
b. Wear glasses	☐ Yes	☑ No
c. Color blind	☐ Yes	☑ No
d. Other eye or vision problem (please indicate)		

11. Have you ever had an injury to your ears, such as a broken ear drum?	☐ Yes	☑ No

12. Do you currently have any of the following hearing problems?		
a. Difficulty hearing	☐ Yes	☑ No
b. Use of a hearing aid	☐ Yes	☑ No
c. Other hearing problem (please indicate)		

13. Have you ever had a back injury?	☐ Yes	☑ No

QUESTIONNAIRE SUBMITTED BY: Ronald Gartrell

14. Do you currently have any of the following?

a. Weakness in your arms, hands, legs, or feet	☐ Yes	☑ No
b. Back pain	☐ Yes	☑ No
c. Difficulty moving your arms and legs	☐ Yes	☑ No
d. Pain or stiffness when leaning forward or backward at the waist	☐ Yes	☑ No
e. Difficulty fully moving your head up or down	☐ Yes	☑ No
f. Difficulty fully moving your head side to side	☐ Yes	☑ No
g. Difficulty bending at your knees	☐ Yes	☑ No
h. Difficulty squatting to the ground	☐ Yes	☑ No
i. Difficulty climbing a flight of stairs or a ladder when carrying more than 25 lbs	☐ Yes	☑ No
j. Other muscular or skeletal problem that interferes with using a respirator (please indicate)		

AUTHORIZATION

I verify to the best of my knowledge, the answers given above are true and correct.

I hereby consent to the necessary collecting and processing of my personal data for the evaluation of my ability to safely wear a respirator. I further consent to the processing and retaining of the information on this questionnaire, as well as any additional information that may be submitted in connection with my evaluation, by the individual branch office of Jehovah's Witnesses which administers the activities of Jehovah's Witnesses in my geographic area. I understand that the transfer of my personal data to the branch office of Jehovah's Witnesses in the United States may be necessary for this evaluation.

Your Signature:	Ronald Gartrell		
Date:	2/15/2024	**Email:**	4ronaldgartrell@jwpub.org
Builder Assistant Volunteer #:	27688393	**Cell Phone:**	

For volunteers who will be wearing a filtering facepiece or a half-face respirator only: *If you answered "Yes" to any of the questions from #2-8, please have your personal healthcare provider complete the following:*

For volunteers who will be wearing a full-face respirator or self-contained breathing apparatus*: If you answered "Yes" to any of the questions from #2-14, please have your personal healthcare provider complete the following:*

HEALTHCARE PROVIDER USE ONLY

The individual named above is approved to wear the respirators checked below. (Check all that apply.)

☐ Particulate respirators (negative pressure types, e.g., filtering facepiece)
☐ Combination respirators (negative pressure types, e.g., half mask with cartridge)
☐ Full facepiece mask respirators (positive pressure types, e.g., powered air-purifying, air-supplied, self-contained breathing apparatus)
☐ Comments or restrictions:

☐ Is **not** approved to wear any respirator. ☐ Patient was notified with the results.

Healthcare Provider's Signature	Type name to indicate signature	**Date:**	