

**EXHIBIT 15B**

**MEDICAL QUESTIONNAIRE FOR RESPIRATOR USERS**  
**SAMPLE**

Name JOHN DOE Social Security No. 123-45-6789  
 Employer PUBLIC WORKS MAINTENANCE Area Supervisor J. WRIGHT  
 Date APRIL 1, 1999 Age 35 Height 6'2" Weight 210

Have you ever worn a respirator before?  Yes  No  
 If YES, describe any apparent difficulties noted with respirator use: \_\_\_\_\_  
 \_\_\_\_\_

-----

Have you had or do you now have any of the following:

	<b>YES*</b>	<b>NO</b>
1. Lung Disease	1. _____	<u>X</u>
2. Persistent cough	2. _____	<u>X</u>
3. Heart trouble	3. _____	<u>X</u>
4. Shortness of breath	4. _____	<u>X</u>
5. History of fainting or seizures	5. _____	<u>X</u>
6. High blood pressure	6. _____	<u>X</u>
7. Diabetes	7. _____	<u>X</u>
8. Fear of tight or enclosed places	8. _____	<u>X</u>
9. Sensation of smothering	9. _____	<u>X</u>
10. Heat exhaustion or heat stroke	10. _____	<u>X</u>
11. Ruptured ear drum	11. _____	<u>X</u>
12. Defective vision	12. _____	<u>X</u>
13. Defective hearing	13. <u>X</u>	_____
14. Contact lenses or glasses	14. _____	<u>X</u>
15. Other conditions that might interfere with respirator use or result in limited work ability	15. _____	<u>X</u>
16. Are you taking any medications?	16. _____	<u>X</u>

\* Please explain YES answers #13 - CLOSE WORK ONLY

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Employee Signature

Date \_\_\_\_\_ Results \_\_\_\_\_

CHEST X-RAY:

PULMONARY REDUCTION TEST: Date \_\_\_\_\_ Normal: \_\_\_\_\_ Abnormal: \_\_\_\_\_

**ABILITY TO USE RESPIRATORY PROTECTION EQUIPMENT**

Qualified: \_\_\_\_\_ Limitations, if any: \_\_\_\_\_ Not qualified: \_\_\_\_\_

**PHYSICIAN'S EVALUATION**

- CLASS: 1. No restrictions on respirator use  
 (Circle) 2. Some specific use restrictions  
 3. No respirator use permitted

Restrictions: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Examining Physician

THIS PAGE INTENTIONALLY LEFT BLANK