Clan Lab physical I

To: Clan Lab Certification Course Students

From: MCTC

OSHA regulations pursuant to 40 CFR 1910.134 require individuals to be medically evaluated and cleared by a physician or other licensed health care professional (PLHCP) before an employer can issue a respirator or before the employee's first use of respirators. Midwest Counterdrug Training Center (MCTC) Clandestine Drug Laboratory Safety Course includes respiratory protection training and exercises involving the use of air-purifying respirators and self-contained breathing apparatus (SCBAs). All students are therefore required to provide MCTC a copy of a current medical evaluation within the last year. **Failure to obtain the medical evaluation executed and signed by a PLHCP will prohibit the successful completion of the course.**

The PLHCP has the option of using a mandatory questionnaire found in 29 CFR 1910.134, Appendix C or to perform a medical examination. To assist you with the required medical evaluation, please provide the attached "MCTC Clandestine Laboratory Safety Class Medical Evaluation Form" to your PLHCP. A copy of the questionnaire is also provided if this option is chosen by PLHCP. If used, the employer and employee should complete the questionnaire prior to visiting the PLHCP.

MCTC can fit test students who have received a medical clearance and who bring their employer-issued respirator to the class. Eligible participants who desire to be fit-tested must also bring a P-100 (purple/magenta-banded cartridge) or any other cartridge equipped with a P-100/HEPA filter for that particular make and model of APR. Students being fit tested can not have beards, excessive side burns or goatees (mustaches are acceptable), that interferes with achieving a proper seal. Students are encouraged to bring their SCBA for use in the practicals. However, we can not fit test the student to the SCBA mask unless the student brings an adapter that converts the mask to a cartridge type respirator.

Training is only one of several requirements before an employee is certified to work at a clandestine drug lab. Certification that allows employees to perform their duties at a clandestine drug lab or any other sites covered by the OSHA 29 CFR 1910.120 standard is the responsibility of the employer. Other OSHA requirements for employer certification will be covered during the course and a handout listing the requirements will be provided to the students.

If you have any questions, please contact us.

MCTC Administrative Office
1-800-803-6532
Email: info@counterdrugtraining.com

MCTC CLANDESTINE LABORATORY SAFETY TRAINING CLASS
MEDICAL EVALUATION FORM

I _____ medically evaluated _____ and as a physician or licensed health care professional approve the use of a respirator as follows:

- The type and weight of the respirator to be used by the employee: Cartridge type, air purifying respirator and/or a self-contained breathing apparatus weighing approximately 30 lb
- The duration and frequency of respirator use: a maximum of two hours (for training exercises)
- The expected physical work effort: some bending, light lifting and walking short distances
- Additional protective clothing and equipment to be worn: Tyvek/Saranex chemical protective suit, inner & outer nitrile gloves, booties and fully taped.
- Temperature and humidity extremes that may be encountered: variable, weather and seasonal dependent.

The medical evaluation is based on (check as appropriate):

___Questionnaire (from 29 CFR 1910.134 Appendix C) completed by the employer and employee

___ Medical examination

Medical professional_____ Date_____

Printed Name_____

****MCTC Students: Please scan/email this page only to info@counterdrugtraining.com or fax it to 515-727-3613. This form is due to us by the Wednesday before the class begins****

OSHA Respirator Medical Evaluation Questionnaire
Appendix C to Sec. 1910.134

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee:

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) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:_____

2. Your name:_____

3. Your age (to nearest year):_____

4. Sex (circle one): Male/Female

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

7. Your job title:_____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____

9. The best time to phone you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

11. Check the type of respirator you will use (you can check more than one category):
a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
b. _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s):_____
_____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you ***currently*** smoke tobacco, or have you smoked tobacco in the last month: Yes/No

2. Have you ***ever had*** any of the following conditions?

   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 places): Yes/No

e. Trouble smelling odors: Yes/No

3. Have you ***ever had*** any of the following pulmonary or lung problems?

   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. Ilicosis: Yes/No
   h. Pneumothorax (collapsed lung): Yes/No
   i. Lung cancer: Yes/No
   j. Broken ribs: Yes/No
   k. Any chest injuries or surgeries: Yes/No
   l. Any other lung problem that you've been told about: Yes/No

4. Do you ***currently*** have any of the following symptoms of pulmonary or lung illness?

   a. Shortness of breath: Yes/No
   b. Shortness of breath when walking fast on level ground or 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. Have 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 produces phlegm (thick sputum): Yes/No
   h. Coughing that wakes you early in the morning: Yes/No
   i. Coughing that occurs mostly when you are lying down: Yes/No
   j. Coughing up blood in the last month: Yes/No
   k. Wheezing: Yes/No
   l. Wheezing that interferes with your job: Yes/No
   m. Chest pain when you breathe deeply: Yes/No
   n. Any other symptoms that you think may be related to lung problems: Yes/No

5. Have you ***ever had*** any of the following cardiovascular or heart problems?

   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. Any other heart problem that you've been told about: Yes/No

6. Have you ***ever had*** any of the following cardiovascular or heart symptoms?

   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 that interferes with your job: Yes/No
   d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No
   e. Heartburn or indigestion that is not related to eating: Yes/No
   f. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

7. Do you ***currently*** take medication for any of the following problems?

a. Breathing or lung problems: Yes/No
b. Heart trouble: Yes/No
c. Blood pressure: Yes/No
d. Seizures (fits): Yes/No

8. If you've used a respirator, have you ***ever had*** any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)

a. Eye irritation: Yes/No
b. Skin allergies or rashes: Yes/No
c. Anxiety: Yes/No
d. General weakness or fatigue: Yes/No
e. Any other problem that interferes with your use of a respirator: Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ***ever lost*** vision in either eye (temporarily or permanently): Yes/No

11. 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. Any other eye or vision problem: Yes/No

12. Have you ***ever had*** an injury to your ears, including a broken ear drum: Yes/No

13. Do you ***currently*** have any of the following hearing problems?

a. Difficulty hearing: Yes/No
b. Wear a hearing aid: Yes/No
c. Any other hearing or ear problem: Yes/No

14. Have you ***ever had*** a back injury: Yes/No

15. Do you ***currently*** have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet: Yes/No
b. Back pain: Yes/No
c. Difficulty fully moving your arms and legs: Yes/No
d. Pain or stiffness when you lean 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. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No
j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

CLANDESTINE LABORATORY SAFETY CERTIFICATION SCHOOL
SUGGESTED GUIDELINES FOR MEDICAL CERTIFICATION

The following elements are suggested for the initial medical evaluation of individuals who are to be considered for a medical clearance to work in clandestine drug laboratories. Additional elements may be added based on local considerations.

I. General Medical History

History of current complaints and illnesses, if any.

Review of systems: special emphasis on the skin, respiratory, cardiovascular and neurologic systems.

Questions about use of respirators and protective gear, including problems with their use and history of claustrophobic reactions.

History of heat injury.

Medications, smoking history, alcohol use.

Reproductive history.

Exercise Capacity.

Occupational and Exposure History.

II. General Medical Examination:

Vital signs. Examination with emphasis on the skin, respiratory, cardiovascular, hepatic and neurologic systems.

III. Laboratory Tests:

CBC

Blood chemistries that include kidney and liver function tests.

Urinalysis.

IV. Other Tests:

Spirometry, including FVC, PEV, and FEF 25-75 conforming to NIOSH standards (70% or greater).

Resting 12 lead electrocardiogram.

Exercise stress test, chest radiograph, and other medical tests if medically indicated.

APPENDIX C

Letter to Physician for Medical Certification of State and Local Officers and Clandestine Laboratory Safety Certification School
Suggested Guidelines for Medical Certification

Dear Doctor:

The purpose of this medical examination is to obtain a medical clearance for work during seizure of illegal drug laboratories in compliance with the worker protection rule for hazardous waste operations and emergency response (29 CFR 1910.120). In addition to traditional law enforcement activities, the examinee will be required to use personal protective equipment for protection from chemical exposures.

The personal protective equipment, workplace and environmental factors of concern are described below. Suggested guidelines for the medical evaluation are attached.

Protective Equipment: Will use a twin cartridge, full face mask, air purifying MSA Ultra twin respirator, and an MSA Airpac (pressure demand, open circuit) self-contained breathing apparatus. Will use neoprene boots, chemically resistant gloves and a chemically resistant (vapor barrier) suit of Tyvek or Saranax.

Type of Work: Includes pursuit, confrontation, control and arrest of suspects which may involve strenuous physical activity. Includes light to moderate exertion while wearing personal protective equipment with increased work of breathing, cardiovascular stress and heat load. Includes responsibility for the safety of others and responsiveness in rescue and emergency situations. Such work may be done daily or once a month or less, up to 8 hours at a time.

Work Setting: Work in uncontrolled, poorly ventilated, makeshift laboratories with unidentified chemical processes in progress. Potential for fire, explosion, and chemical spills likely. Potential for exposure to organic solvents, inorganic acids and alkalis, cyanides, other drug precursors, unknown chemicals, reactants, and by-products of chemical reactions, controlled substances in solution or powdered form. Includes work indoors and outdoors in extremes of seasonal environmental temperatures and humidity. Prior acclimation to hot environment is unlikely.

If there are any abnormalities such as cardiovascular or respiratory conditions, musculoskeletal problems, lapses of consciousness, sensitivity to heat injury, or other medical conditions that would present an unusual risk of harm in the individual or to others in performing these duties, please notify me as soon as possible.

If you find the individual cleared for performing the duties described above, please sign and date the certification below and return it to me. Thank you for your help.

Sincerely yours,

Chief Medical Officer

Medical Certification

I examined _____ on _____ and
(name) (Date)
find the individual to be medically able to perform the duties described above without unusual medical risk of harm to the individual or others.
Physician's Signature: _____ Date: _____

Physician's Name: _____ Date: _____