RESPIRATOR MEDICAL CLEARANCE PHYSICIAN'S WRITTEN OPINION

EMPLOYER: ____

EMPLOYEE: ____

Type of Respirator to be worn (check all that apply):

_____filtering facepiece (ex. N95)

_____half-face air purifying respirator

_____full face air purifying respirator

_____ other (specify): _________________________________

The above referenced employee was evaluated on _____________________ (date) for medical fitness to wear the respirator(s) indicated above based on:

____ Review of his/her OSHA Respirator Medical Evaluation Questionnaire

____ Blood pressure screening (optional)

____ Spirometry (lung function screening) (optional)

____ Hands-on physical exam (optional)

Based on these findings, the above referenced employee has been determined to be:

_____ Medically cleared, no restrictions on respirator use.

_____ NOT medically cleared, significant restrictions on respirator use.

_____Medically cleared with limitations. There are partial restrictions on respirator use and the employee has been informed of these limitations and the importance of managing medical condition(s).

_____Medical clearance on hold until further medical evaluation has been conducted.

Comments: ____

____
Signature of Physician or Licensed Healthcare Professional

____
Street Address

____
Print Name

____
City/State/Zip

____
Name of Clinic (if different)

____
Phone

This clearance is valid: ______until a change occurs in employee's medical condition

______1 years (Date):____________________

______2 years (Date):____________________

REMEMBER TO PROVIDE A COPY OF THIS FORM FOR THE INDIVIDUAL AND THEIR EMPLOYER