RESPIRATOR MEDICAL CLEARANCE
PHYSICIAN'S WRITTEN OPINION

EMPLOYER: ____

EMPLOYEE: ____

The above referenced employee has been evaluated for medical fitness to wear a respirator 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 have:

_____No restrictions on respirator use and is medically cleared

_____Significant restrictions on respirator use and is NOT medically cleared

_____Partial restrictions on respirator use and is medically cleared with limitations. Employee has been Informed of limitations and on the importance of managing medical condition(s).

_____Opinion of respirator use is being withheld until further medical evaluation has been conducted.

Comments: ____

______________________________________ ______________________________________
Signature of Licensed Healthcare Provider Date

____
Print Name of Physician/Clinic

____
Address

____
Phone

This clearance is valid: ______until a change occurs in employee's medical condition
______1 years (Date):_____________________
______2 years (Date):_____________________