RESPIRATOR MEDICAL CLEARANCE LICENSED HEALTHCARE PROFESSIONAL'S WRITTEN OPINION

EMPLOYER:			
Type of Respirator to be worn (check all that apply): filtering facepiece (ex. N95)half-face air purifying respiratorfull face air purifying respirator other (specify):			
		The above referenced employee was evaluated on wear the respirator(s) indicated above based on (check all	
		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 l	nas been determined to be:		
Medically cleared, no restrictions on respirator use.			
NOT medically cleared, due to significant restrictions on respirator use.			
Medically cleared with limitations. There are partial has been informed of these limitations and the impo			
Medical clearance on hold until further medical evalu	uation 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 (based on Licensed Healthcare Providence of Licensed Healthcare Providence Office (Licensed Healthcare Providence Healthcare Providence Healthcare Providence Healthcare Providence Office (Licensed Healthcare Providence Healthcare Providence Healthcare Providence Healthcare Providence (Licensed Healthcare Providence Healthcare Providence Healthcare Providence Healthcare Providence (Licensed Healthcare Providence Healthcare Providence Healthcare Providence Healthcare Providence (Licensed H	oyee's medical condition		

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