**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 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**