**RESPIRATOR MEDICAL CLEARANCE**
**LICENSED HEALTHCARE PROFESSIONAL'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 (check all that were completed):**

____ 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, due to 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 (based on Licensed Healthcare Provider's Medical Opinion):
_____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**