RESPIRATOR MEDICAL CLEARANCE
LICENSED HEALTHCARE PROFESSIONAL'S WRITTEN DETERMINATION

EMPLOYER: _____

EMPLOYEE: _____

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

_____filtering facepiece (e.g., 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 Determination):
_____until a change occurs in employee's medical condition
_____1 years (Date):_____
_____2 years (Date):_____

A COPY OF THIS WRITTEN MEDICAL DETERMINATION HAS BEEN PROVIDED TO THE EMPLOYEE

Adapted from Form Developed by NC Agromedicine Institute 252.744.1008