MEDICAL CLEARANCE FOR RESPIRATOR USE

Your employer is required under OSHA Standard 1910.134 to ensure that you are medically certified to wear a respirator as part of your job. The following describes the respirator type and use conditions your employer assigned you to test for and the physician's evaluation of your ability to wear the respirator based on the information you provided.

Complete and bring this medical clearance form and the OSHA Respirator Medical Evaluation Questionnaire (Appendix C of 29 CFR 1910.134) to your medical evaluation appointment with your physician.

Employee Name: _____

Employer Name: _____

Employer Contact Info: _____

Respirator Use Conditions

(EMPLOYER completes questions 1 to 6)

1. Respirator Type (check all respirators the employee named above will use; also see pg. 4):

☐ Particulate ☐ Full Face ☐ Half Face ☐ Powered Air Purifying Respirator (PAPR)

☐ Escape Hood ☐ Supplied Air ☐ Self Contained Breathing Apparatus (SCBA)

2. Substance Exposure:

This medical evaluation is for the use of one or more types of respirator(s) selected in question 1 and for the handling, use, and application of organic and/or conventional pesticides (herbicides, insecticides, fungicides, miticides, etc.). If handling, using, and/or applying anything other than pesticides, note them below.

_____

3. Respirator Usage (how frequent will the employee use a respirator)**:**

	Select all that apply
2 to 4 hours per day	
Over 4 hours per day	
Daily, but less than 2 hours per day	
Weekly, but less than 5 hours per week	
Less than 5 hours per month	
Hazmat / Spill	

Other:	

4. Work Effort (select work effort with a respirator that best fits the employee)**:**

		Select one
Sedentary	Defined as infrequent lifting of <10 lb.; no walking / carrying	
Light	Defined as frequent lifting of 10 lb.; infrequent lifting of <20 lb.; walking on level; carrying up to 10 lb.	
Medium	Defined as frequent lifting of 25 lb.; infrequent lifting of <50 lb.; fast walking on level; carrying up to 25 lb.	
Heavy	Defined as frequent lifting of 50 lb.; infrequent lifting of <100 lb.; fast walking on level; carrying up to 50 lb.	
Very Heavy	Defined as work that is consistently of greater effort than heavy	

5. Environmental Conditions of Work with a Respirator (yes or no):

	Yes	**No**
Temp. <55°F		
Temp. >77°F		
Permit Required Confined Space		
Oxygen Deficient		
Humid Conditions		
Hyperbaric (ie: diver)		
High Altitude (ie: pilot)		

6. Protectant Gear Used (while using respirator)**:**

	Select all that apply
Boots, Shoe Covers	
Eye Protection (ie: goggles, faceshield)	
Gloves	
Skin Protection (ie: apron, coveralls, Tyvek suit)	
Hearing Protection (ie: ear plugs, ear muffs)	
Head Protection (ie: helmet, hard hat, head cover)	
Other (identify)	

PHYSICIAN'S EVALUATION

(Completed by a primary care physician or certified health care professional (CHCP) ONLY)

This completed and signed form MUST be provided by the respirator user before the fit test organizers will conduct respirator fit testing.

Patient / Employee Name: _____

Date of Medical Evaluation: _____

Select one	Can the employee / patient named above use the selected respirators, and in the conditions indicated by the employer?	Physician's Initial
	NO - The employee named above is NOT fit or certified to use a respirator.	
	NO, FURTHER TESTING IS NEEDED – The employee must undergo additional testing to determine fitness for respirator use.	
	YES – There are **no restrictions** on respirator use in the use conditions listed by the employer.	
	YES, BUT ONLY with the following restrictions listed below:	

The employee must recertify:

☐ Within one year or when there is a change in health or work conditions.

☐ IF sooner, indicate frequency of recertification: _____

_____

Physician / CHCP's Name: _____

Signature: _____

Date: _____

Name and Contact of Physician / CHCP's Practice: _____

_____

_____

Types of Respirators

Particulate (includes N95)

Full Face

Half Face

PAPR

Escape Hood

Supplied Air

SCBA