TEMPLE UNIVERSITY

Environmental Health and Radiation Safety

Respiratory Medical Clearance Form

The Occupational Safety and Health Administration (OSHA) requires that a person be medically evaluated by a physician or other licensed health-care professional to determine whether, and under what conditions, a worker (or student if applicable) can safely wear a respirator. This form allows your physician or other licensed health-care professional to indicate whether you are medically cleared to safely wear a respirator in the course of your work without disclosing confidential medical information.

To be completed after a medical evaluation that includes review of the OSHA Respirator Medical Evaluation Questionnaire (Mandatory) Appendix C of 29 CFR 1910.134.

To be completed by the Respirator User:

Name: ______________________________________

TuID#: ______________________________________

Department/School: __________________________

Telephone #:_________________________________

Email: ______________________________________

To be completed by a Physician or Other Licensed Health Care Professional:

I have performed a respirator medical evaluation, including a review of the individual's OSHA Respirator Medical Evaluation Questionnaire Appendix C of 29 CFR 1910.134.

The identified individual is approved to wear (check all that apply):

N95 particulate respirator	☐ Without restrictions	☐ With restrictions ________________________
Full-face, air purifying respirator	☐ Without restrictions	☐ With restrictions ________________________
Powered air purifying respirator	☐ Without restrictions	☐ With restrictions ________________________

If applicable, the following workplace conditions will result in additional physiological burden: ___________________________
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- Follow-up medical evaluation is required if ANY of the following occur prior to approval:
  - a positive response to any question among questions 1 through 8 in Section 2, Part A of the OSHA Respirator Medical Evaluation Questionnaire Appendix C was provided by the above identified individual; or,
  - the initial medical examination demonstrates the need for a follow-up medical examination.

☐ This user is approved to wear a respirator. Approval date: ___________________________

☐ This user is not approved to wear a respirator.

I have provided the above identified individual a copy of this form: ☐Yes ☐No

Physician or Other Licensed Health Care Professional:

Printed name: ________________________________ Signature: ___________________________________

Company Name: _____________________________ Date: _______________________________________

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