

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 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	<input type="checkbox"/> Without restrictions	<input type="checkbox"/> With restrictions _____
Half-mask, air purifying respirator	<input type="checkbox"/> Without restrictions	<input type="checkbox"/> With restrictions _____
Full-face, air purifying respirator	<input type="checkbox"/> Without restrictions	<input type="checkbox"/> With restrictions _____
Powered air purifying respirator	<input type="checkbox"/> Without restrictions	<input type="checkbox"/> With restrictions _____

If applicable, the following workplace conditions will result in additional physiological burden: _____

- 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.