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RESPIRATOR REQUIREMENTS

Patient Information

Last _____ First _____ M.I. _____

Birthdate ____/____/____ Last 4 Digits of S.S. XXX/XX/____

Company Information

Employer _____ Employer Phone Number _____ Job Classification: _____

Type of respirator(s) this individual/job required (Check all that apply)

<input type="checkbox"/> Half-mask	<input type="checkbox"/> Full face	<input type="checkbox"/> Helmet Hood	<input type="checkbox"/> TB Mask
<input type="checkbox"/> Non-Powered cartridge or canister	<input type="checkbox"/> Powered air-purifying cartridge respirator (PAPR)	<input type="checkbox"/> Disposable filtering face-piece	<input type="checkbox"/> Self-contained breathing apparatus (SCBA)
<input type="checkbox"/> Demand	<input type="checkbox"/> Pressure	<input type="checkbox"/> Other	<input type="checkbox"/> Escape

Exposure Risks

<input type="checkbox"/> Dust	<input type="checkbox"/> Asbestos	<input type="checkbox"/> Benzene	<input type="checkbox"/> Lead
<input type="checkbox"/> Hazardous waste	<input type="checkbox"/> Particulate	<input type="checkbox"/> TB	<input type="checkbox"/> Smoke
<input type="checkbox"/> Irritant Fumes	<input type="checkbox"/> Temperature extreme	<input type="checkbox"/> Confined spaces	<input type="checkbox"/> Other

Workload:

<input type="checkbox"/> Varies	<input type="checkbox"/> Heavy	<input type="checkbox"/> Medium	<input type="checkbox"/> Light
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Frequency of use

>20 hours/week >1hr/day >1 hr/month Evacuation/escape only Emergency response team

Company Representative Signature: _____

Recommendations Based On: Questionnaire Only Questionnaire and physical exam

Respirator Clearance

Under the conditions described in the above information provided by the employer, this individual:

Is medically cleared for use of the respirator(s) without limitations
 Is medically cleared for use of the respirator(s) with the following limitations: _____

Is not medically cleared to use a respirator

Workload Limitations: Unrestricted Medium Heavy Light

Follow up Medical Evaluations

<input type="checkbox"/> This individual will not require additional follow-up medical evaluation(s)
<input type="checkbox"/> This individual will require additional follow-up medical evaluations(s). The recommended follow-up is as follows:

Employer Notification

I (a Professional Licensed Health Care Provider: PLHCP) certify that the employer for the above named individual for whom this respirator clearance form is provided, has received a copy of this recommendation. This recommendation is valid for _____ years, or sooner due to change of job or change in state of health.

Signature of PLHCP _____ Date _____