Respirator Medical Recommendation Form

Employee name: ____________________________________________________

Agency name: ______________________________________________________

This form outlines the results of the Occupational Safety and Health Administration (OSHA) Respirator Medical Evaluation. If you have any questions regarding this evaluation please call (fill in your county health department name and number here. You can refer their questions to this person).

This form must be completed by a licensed medical provider.

Based on review of the OSHA Respirator Medical Evaluation Questionnaire (Mandatory) this individual is:

_____ Medically approved for all respirators, with the exception of SCBA, and subject to fit test.

_____ Not approved for respirator use at this time. Follow-up medical evaluation is needed.

Date: ____________________

Signature: _____________________________