Date: [Date]

To: [Agency Name/Employer Name]
From: [Medical Provider Name/Clinic Name]
Subject: OSHA Respirator Medical Evaluation Clearance

Patient Name: [Officer Name]
Employee ID/Badge #: [ID Number]

To Whom It May Concern,

In accordance with the OSHA Respiratory Protection Standard (29 CFR 1910.134), I have performed a medical evaluation on the above-named individual to determine their physical ability to use a respirator while performing law enforcement duties.

Based on this evaluation, the following determination has been made (checked below):

[ ] **CLEARED:** The individual is medically cleared to wear the following type(s) of respirator(s) without restrictions:
(e.g., N95, Full-Face APR, SCBA, Gas Mask)

[ ] **CLEARED WITH RESTRICTIONS:** The individual is cleared to wear a respirator with the following limitations:
[List restrictions here]

[ ] **NOT CLEARED:** The individual is not medically cleared to wear a respirator at this time.

Medical Follow-up:
The next scheduled medical evaluation is recommended in [Number] year(s), or if the employee reports medical signs or symptoms related to respirator use, or if workplace conditions change.

I have provided the employee with a copy of this written recommendation.

Provider Signature: _____
Provider Name: [Printed Name]
License/Credential: [MD, DO, NP, PA-C]
Clinic Address: [Address]
Phone Number: [Phone]