Date: [Date]

To: [Employer Name/Company Name]

From: [Medical Provider Name/Clinic Name]

Medical Evaluation Clearance for Respirator Use

Employee Name: [Employee Full Name]

Employee ID/DOB: [ID Number or Date of Birth]

In accordance with OSHA Respirator Protection Standard 29 CFR 1910.134, a medical evaluation has been performed on the above-named employee to determine their ability to use a respirator.

Clearance Status (Check One):

[ ] The employee is **cleared** to use the following types of respirators without restrictions:

- Disposable (N, R, or P series)
- Half-mask air-purifying
- Full-facepiece air-purifying
- Powered Air-Purifying Respirator (PAPR)
- Self-Contained Breathing Apparatus (SCBA)

[ ] The employee is **cleared** to use a respirator with the following **restrictions/limitations**:

[Insert restrictions, e.g., PAPR only, limited duration, etc.]

[ ] The employee is **not cleared** to use a respirator at this time.

Follow-up Requirements:

A follow-up medical evaluation is required on: [Date or N/A]

Healthcare Provider Information:

Name: [Provider Name and Title]

Signature: _____

Clinic Address: [Address]

Phone: [Phone Number]

Note to Employer: A copy of this written recommendation must be provided to the employee. This document does not contain confidential medical information.