Date: [Insert Date]

To: [Employer Name/Company Name]

Subject: UNRESTRICTED RESPIRATOR MEDICAL CLEARANCE

Employee Name: [Insert Employee Full Name]

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

To Whom It May Concern,

I have evaluated the above-named individual in accordance with OSHA Respirator Protection Standard 29 CFR 1910.134. Based on the medical evaluation and/or questionnaire, the following determination has been made:

Clearance Status: UNRESTRICTED

The employee is medically cleared to wear the following types of respirators:

- Filtering Facepiece (N95, N99, N100)
- Half-Facepiece Respirator
- Full-Facepiece Respirator
- Powered Air-Purifying Respirator (PAPR)
- Self-Contained Breathing Apparatus (SCBA)

Limitations: None. There are no medical restrictions placed on this employee regarding the use of the equipment listed above.

Follow-up: This clearance is valid until [Insert Expiration Date] or unless there is a change in the employee's health status, workplace conditions, or physiological burden that may affect respirator use.

Sincerely,

[Signature of PLHCP]
[Printed Name of Physician or Licensed Health Care Professional]
[Medical License Number]
[Clinic/Facility Name]
[Phone Number]