Date: [Date]

To: [Employer Name / Safety Officer]

From: [Physician or Licensed Health Care Professional Name]

Subject: Restricted Respirator Fit Test Medical Clearance

Employee Name: [Employee Full Name]

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

I have evaluated the above-named individual in accordance with OSHA Respirator Medical Evaluation Questionnaire standards (29 CFR 1910.134).

Based on this evaluation, the individual is **CLEARED WITH RESTRICTIONS** to perform a respirator fit test and wear a respirator under the following conditions:

1. Specific Restrictions:
[Example: Time limit of 2 hours per shift / No strenuous lifting while wearing / No use of SCBA]

2. Approved Equipment:
[Example: N95 or Half-Face P100 only]

3. Medical Follow-up:
This clearance is valid until [Expiration Date]. A re-evaluation is required if the employee reports breathing difficulties or if workplace conditions change significantly.

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

_____
Healthcare Provider Signature

[Provider Name and Credentials]
[Facility Name/Address]
[Phone Number]