Date: [Date]

To: [Employee Name]
Employee ID: [ID Number]

Subject: NOTICE OF MEDICAL NON-CLEARANCE FOR RESPIRATOR USE

Dear [Employee Name],

Based on the review of your OSHA Respirator Medical Evaluation Questionnaire and/or your recent clinical examination conducted on [Date], it has been determined that you are **not medically cleared** to undergo respirator fit testing or to use a respirator at this time.

This determination has been made based on the following criteria:

- [Insert specific reason, e.g., underlying health condition, pulmonary function results, etc.]

Recommended Next Steps:

- You are advised to follow up with your primary care physician or a specialist for further evaluation regarding [Condition].
- A re-evaluation for respirator clearance may be requested after [Timeframe or Clinical Milestone].
- Please contact the Human Resources Department to discuss how this medical determination impacts your current job duties and to explore potential accommodations.

Please note that this evaluation is strictly for the purpose of determining your ability to safely wear a respirator under OSHA standard 29 CFR 1910.134 and is not a comprehensive health assessment.

Sincerely,

[Signature of Licensed Healthcare Professional]
[Name of Healthcare Professional]
[Title/Credentials]
[Medical Facility Name]

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cc: [Human Resources/Safety Department]