Date: [Date]

To: [Employer Name/Program Administrator]

From: [Name of Licensed Healthcare Professional]

Subject: Conditional Medical Clearance for Respirator Use

Employee Name: [Employee Full Name]
Employee ID/SSN (Last 4): [ID Number]

I have completed a medical evaluation of the above-named employee in accordance with OSHA Respirator Protection Standard 29 CFR 1910.134. Based on this evaluation, the employee is **CONDITIONALLY CLEARED** to undergo a respirator fit test and wear a respirator with the following specific limitations and requirements:

1. Respirator Type(s) Allowed:
[e.g., N95, Half-mask, Full-facepiece, PAPR]

2. Mandatory Conditions/Restrictions:
[e.g., Use restricted to 2 hours per shift, Must not exceed specific heart rate, Use of PAPR only, No strenuous lifting while wearing, etc.]

3. Medical Follow-up Required:
This clearance is valid until: [Expiration Date].
A follow-up evaluation is required on or before [Date] or if the employee experiences any respiratory distress or changes in health status.

4. Healthcare Provider Statement:
I have provided the employee with a copy of this written recommendation. The employee has been informed of the results of the evaluation and any medical conditions that may require further follow-up.

Signature: _____

Provider Name: [Print Name]
Title: [e.g., MD, DO, PA, NP, RN]
Facility/Clinic: [Name of Practice]
Phone Number: [Phone Number]