**Date:** [Insert Date]

**To:** [Employer Name/Safety Officer]

**From:** [Name of Licensed Healthcare Professional]

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## SUBJECT: MEDICAL EVALUATION CLEARANCE FOR RESPIRATOR USE

**Employee Name:** [Insert Employee Name]

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

I have completed a medical evaluation of the above-named employee in accordance with OSHA Respirator Protection Standard 29 CFR 1910.134.

**Determination:**

[ ] The employee is **CLEARED** to wear the following type(s) of respirator(s) without restrictions:
*(e.g., N95, Half-mask, Full-face, SCBA)*: [Insert Types]

[ ] The employee is **CLEARED WITH RESTRICTIONS**.
List restrictions: [Insert Restrictions, e.g., time limits, weight limits]

[ ] The employee is **NOT CLEARED** to wear a respirator.

**Follow-up Requirements:**

- Annual fit testing is required.
- Medical re-evaluation is required on: [Insert Date] or if the employee reports medical signs/symptoms related to respirator use.

The employee has been provided with a copy of this written recommendation.

**Healthcare Professional Signature:** _____
**Print Name:** [Insert Name]
**License/Credential:** [Insert Credentials]
**Facility Name:** [Insert Facility Name]