Date: [Insert Date]

To: [Employer Name / Company Name]

From: [Healthcare Provider Name/Clinic Name]

Subject: Medical Evaluation for Respirator Use

Employee/Candidate Name: [Insert Name]

Date of Evaluation: [Insert Date]

Dear [Contact Person],

I have completed a medical evaluation of the individual named above in accordance with OSHA Respirator Protection Standard 29 CFR 1910.134. Based on the evaluation, the following determination has been made:

Medical Status:

- [ ] **Cleared:** The individual is medically cleared to wear the following types of respirators: [e.g., N95, Half-mask, Full-face] without restrictions.
- [ ] **Cleared with Restrictions:** The individual is medically cleared to wear a respirator with the following limitations: [Insert restrictions].
- [ ] **Not Cleared:** The individual is not medically cleared to wear a respirator at this time.

Follow-up:

This clearance is valid until [Insert Expiration Date] or until there is a change in the employee's health status or workplace conditions that may affect respirator use.

A copy of this written recommendation has been provided to the employee.

Sincerely,

[Signature of Healthcare Professional]
[Printed Name and Title]
[License Number]
[Phone Number]