Date: [Insert Date]

To: [Employer Name/Occupational Health Department]

From: [Name of Licensed Healthcare Professional]

Medical Evaluation Clearance for Respirator Use

Employee Name: [Insert Employee Name]

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

In accordance with OSHA Respiratory Protection Standard 29 CFR 1910.134, a medical evaluation has been performed on the above-named individual to determine their ability to use a respirator.

Determination:

- The employee is **CLEARED** to wear an N95 filtering facepiece respirator without restrictions.
- The employee is **CLEARED** to wear an N95 filtering facepiece respirator with the following **RESTRICTIONS**: [Insert restrictions if any, or N/A]
- The employee is **NOT CLEARED** to wear an N95 filtering facepiece respirator.

Recommended Frequency: This clearance is valid until [Insert Expiration Date] or until a change in the employee's health status or workplace conditions occurs.

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

Healthcare Provider Signature: _____
Provider Name: [Insert Name and Credentials]
Facility Name: [Insert Clinic/Hospital Name]
Contact Phone: [Insert Phone Number]