Respirator Medical Evaluation Clearance Certificate

Date: [Insert Date]

Employee Name: [Insert Employee Name]

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

Company Name: [Insert Company Name]

The above-named individual has been medically evaluated in accordance with OSHA Respiratory Protection Standard 29 CFR 1910.134.

Medical Determination:

[ ] **CLEARED:** The individual is medically cleared to wear a half-mask respirator without restrictions.

[ ] **CLEARED WITH RESTRICTIONS:** The individual is cleared to wear a half-mask respirator with the following limitations:
[Insert Restrictions here, e.g., time limits, specific environments]

[ ] **NOT CLEARED:** The individual is not medically cleared to wear a respirator at this time.

Follow-up Requirements:

This clearance is valid until: [Insert Expiration Date].
The employee must be re-evaluated if there are changes in workplace conditions or if the employee reports medical signs/symptoms related to respirator use.

Healthcare Provider Information:

Name: [Insert Name of PLHCP]
Title: [Insert Title]
Facility Name: [Insert Clinic/Hospital Name]
Phone: [Insert Phone Number]
Signature: _____