Date: [Date]

To: [Employer Name/Company]
From: [Name of Licensed Healthcare Professional]
Subject: Medical Evaluation for Full-Facepiece Respirator Use

Employee Name: [Employee Full Name]
Employee ID/Date of Birth: [ID or DOB]

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 following determination has been made regarding the use of a **Full-Facepiece Respirator**:

Status (Check one):

- [ ] **Cleared:** The employee is medically cleared to wear a full-facepiece respirator without restrictions.
- [ ] **Cleared with Restrictions:** The employee is cleared to wear the respirator with the following limitations: [List restrictions, e.g., time limits, specific environments].
- [ ] **Not Cleared:** The employee is not medically cleared to wear a full-facepiece respirator at this time.

Follow-up Requirements:
Re-evaluation is required if the employee reports medical signs or symptoms related to respirator use, if the workplace conditions change significantly, or by the following date: [Expiration Date].

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

Healthcare Provider Signature: _____
Name and Title: [Provider Name, Degree/Credentials]
Facility Name: [Clinic/Hospital Name]
Contact Information: [Phone Number/Address]