Respirator Fit Test Medical Clearance Letter

Date: [Insert Date]

To: [Employer Name / Safety Department]

Employee Name: [Insert Employee Name]

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

Dear Health and Safety Officer,

I have evaluated the above-named individual in accordance with OSHA Respirator Medical Evaluation Questionnaire requirements (29 CFR 1910.134). Based on the medical evaluation, the following determination has been made regarding the employee's ability to use a respirator:

Clearance Status (Check One):

- [ ] **Cleared:** The employee is medically cleared to undergo qualitative fit testing and use the respirator(s) specified below without restrictions.
- [ ] **Cleared with Restrictions:** The employee is cleared to use a respirator with the following limitations: [Insert Restrictions, e.g., time limits, specific mask types only].
- [ ] **Not Cleared:** The employee is not medically cleared to use a respirator at this time.

Approved Respirator Type(s):
[ ] N95 / Disposable Filtered Facepiece
[ ] Half-face Elastomeric
[ ] Full-face Elastomeric
[ ] Powered Air Purifying Respirator (PAPR)

Recommended Re-evaluation Date: [Insert Date, usually 1-2 years]

The employee has been provided with a copy of this written recommendation. This evaluation only addresses medical clearance; a qualitative fit test must still be performed to ensure proper seal and sizing.

Healthcare Provider Signature: _____

Provider Name/Title: [Insert Name and Credentials]

Facility Name: [Insert Clinic/Hospital Name]

Contact Information: [Insert Phone Number]