Quantitative Respirator Fit Test Medical Clearance

Date: [Date]

Employee Name: [Employee Name]

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

Company Name: [Company Name]

Based on the medical evaluation conducted in accordance with OSHA Respirator Protection Standard 29 CFR 1910.134, the above-named individual has been evaluated for the use of a respirator.

Medical Determination:

- [ ] Cleared for respirator use with no restrictions.
- [ ] Cleared for respirator use with the following restrictions: [List Restrictions]
- [ ] Not cleared for respirator use.

Type of Respirator(s) Allowed:

- [ ] N, R, or P series disposable (Filtering facepiece)
- [ ] Half-facepiece elastomeric
- [ ] Full-facepiece elastomeric
- [ ] Powered Air Purifying Respirator (PAPR)
- [ ] Self-Contained Breathing Apparatus (SCBA)

Evaluation Frequency:

The next medical evaluation is required on: [Date] or if the employee reports medical signs or symptoms related to respirator use.

Healthcare Provider Information:

Provider Name: [Name of PLHCP]
Title: [e.g., MD, NP, PA]
Facility Name: [Clinic/Hospital Name]
Phone Number: [Phone Number]

Signature: _____