

**Date:** [Insert Date]

**To:** [Employer Name]

**Address:** [Employer Address]

**Subject:** Annual Asbestos Worker Medical Clearance Letter

**Employee Name:** [Insert Employee Full Name]

**Employee ID/Last 4 Digits of SSN:** [Insert ID]

To Whom It May Concern,

In accordance with OSHA Standard 29 CFR 1910.1001 and 29 CFR 1926.1101, a medical examination was performed on the above-named individual on [Date of Examination].

Based on the medical history, physical examination, and lab results, I have determined the following:

**1. Medical Results:** The employee has been informed by the physician of the results of the medical examination and any medical conditions that may result from asbestos exposure.

**2. Work Limitations:** [Select One]

There are NO recommended limitations on the employee's assigned work.

The employee has the following work limitations: [Insert Limitations]

**3. Respirator Use:** [Select One]

The employee is physically able to wear a respirator while performing their duties.

The employee is NOT physically able to wear a respirator.

This evaluation meets the requirements for annual medical surveillance for workers exposed to airborne concentrations of asbestos at or above the permissible exposure limit (PEL) or excursion limit.

Sincerely,

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**Physician/Provider Signature**

**Name:** [Physician Name]

**Clinic Name:** [Clinic/Facility Name]

**Phone Number:** [Phone Number]