Date: [Insert Date]

To: [Employer Name/Company Name]
From: [Physician Name/Medical Facility]
Subject: Temporary Medical Restriction - Asbestos Work Clearance

Employee Name: [Insert Employee Name]
Date of Birth: [Insert DOB]
Date of Examination: [Insert Date]

To Whom It May Concern,

In accordance with OSHA Asbestos Standards (29 CFR 1910.1001 / 1926.1101), a medical evaluation has been performed on the above-named individual to determine their fitness for working in asbestos-regulated areas and for the use of respiratory protection.

Medical Determination:

The employee is **Temporarily Restricted** from working in asbestos-regulated areas and from using a respirator at this time. This restriction is effective immediately and will remain in place until [Insert End Date or "further clinical evaluation is completed"].

Reason for Restriction:
The employee has a temporary medical condition that may prevent them from safely performing assigned tasks or using required personal protective equipment. (Note: Specific medical diagnoses are confidential and are not included in this summary).

Follow-up Requirements:
The employee is scheduled for a re-evaluation on [Insert Date]. A final determination of fitness for duty will be issued following that appointment.

Physician Statement:
I have informed the employee of the results of this medical examination and any medical conditions that require further explanation or treatment.

Respectfully,

[Physician Signature]
[Physician Name, MD/DO]
[Medical Facility Name]
[Phone Number]