

Date: [Insert Date]

To: [Employer Name/Company Name]

From: [Physician or Licensed Health Care Professional Name]

Medical Evaluation Clearance for Respirator Use

Employee Name: [Insert Employee Name]

Employee ID/SSN (Optional): [Insert ID]

Date of Medical Evaluation: [Insert Date]

In accordance with OSHA Respiratory Protection Standard 29 CFR 1910.134 and Asbestos Standard 29 CFR 1910.1001 / 1926.1101, a medical evaluation has been performed on the above-named employee to determine their ability to use a respirator while working with or around asbestos.

Determination:

- The employee is **CLEARED** to wear a respirator without restrictions.
- The employee is **CLEARED** to wear a respirator with the following **LIMITATIONS**:
[Insert Restrictions, e.g., type of respirator, duration of use].
- The employee is **NOT CLEARED** to wear a respirator.

Type of Respirator(s) Authorized:

- Disposable (N95, etc.)
- Half-mask Air Purifying Respirator (APR)
- Full-face Air Purifying Respirator (APR)
- Powered Air Purifying Respirator (PAPR)
- Self-Contained Breathing Apparatus (SCBA) / Supplied Air

Health Care Provider Statement:

I have provided the employee with a copy of this written recommendation. This evaluation is based on the medical history and/or physical examination of the employee. No confidential medical information has been disclosed to the employer in this document.

Follow-up Evaluation Date: [Insert Date or "Annual"]

Signature of Physician or Licensed Health Care Professional

[Professional License Number]

[Clinic Name/Address]

[Phone Number]