EMPLOYER AUTHORIZATION AND INFORMATION FOR RESPIRATORY EVALUATION

EMPLOYER TO COMPLETE THE FOLLOWING :

Employee Name: _____

Address: _____

_____

_____

Employer: _____

Employee SSN: _____

Check Type of Respirator(s) To Be Used **(Check ✓ALL that apply)**

- ☐ Air-purifying (non-powered)
- ☐ Air-purifying (powered)
- ☐ Atmosphere supplying Respirator
- ☐ Combination air-line and SCBA
- ☐ Continous-Flow Respirator
- ☐ Supplied-Air Respirator
- ☐ Open Circuit SCBA
- ☐ Closed Circuit SCBA
- ☐ Dust Mask
- ☐ 1/2 Face with Canisters
- ☐ Full Face with Canisters

Make: _____ Model: _____ Cartridge: _____

Special Work Conditions (Check ✓ ALL That Apply When Wearing Respirator)

- ☐ High Places
- ☐ Enclosed Places
- ☐ Protective Clothing
- ☐ Temperature Extremes
- ☐ Mostly Cold
- ☐ Mostly Hot
- ☐ Other: _____

Questionare will be: ☐ HAND CARRIED ☐ MAILED ☐ OTHER

Extent of Useage **(Check ✓ALL that apply)**

- ☐ On a daily basis _____ Total Hours
- ☐ Occasionally - but not more than twice a week ____ Total Hours
- ☐ Rarely - or for Emergency situations only ____ Total Hours

Expected Physical Effort Required **(Check ✓ALL that apply)**

- ☐ Light
- ☐ Moderate
- ☐ Heavy

Exposure to Hazardous Materials **(Check ✓ALL that apply)**

- ☐ Arsenic
- ☐ Benzene
- ☐ Coke Oven
- ☐ Cotton Seed / Dust
- ☐ Cadmium
- ☐ Formaldehyde
- ☐ Methylene Chloride
- ☐ Lead
- ☐ Textiles
- ☐ Chromium

Other(s): _____

EVALUATION AUTHORIZATION BY: _____
Signature of Employer Representative

DO NOT WRITE BELOW THIS LINE **DO NOT WRITE BELOW THIS LINE** **DO NOT WRITE BELOW THIS LINE**

PLHCP[1] WRITTEN STATEMENT for RESPIRATORS (EMPLOYER)

PHYSICIAN WILL COMPLETE THE FOLLOWING

This report may contain confidential medical information and is intended for the designated employer contact only. The Americans with Disabilities Act (ADA) imposes very strict limitations on the use of information obtained during physical examination of qualified individuals with disabilities. All information must be collected and maintained on seperate forms, in seperate files, and must be treated as a confidential medical record, with the following exceptions:

- Supervisors and managers may be informed about necessary restrictions on the work or duties of an employee and necessary accommodations.
- First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment.

Based upon my findings, I have determined that this individual **(Check ✓ALL that apply)**

- ☐ Employee must schedule a medical examination with _____ prior to respirator approval and usage.
- ☐ Class I - No Restrictions on Respirator Use
- ☐ Class II - Some Specific Use Restrictions
- ☐ To be used for Emergency Response or Escape Only
- ☐ Other: _____
- ☐ Class III - Respirator Use is NOT PERMITTED
- ☐ Further Testing / Evaluation is Required. [2]
- ☐ Fit Test Required
- ☐ Fit Test Performed Satisfactorily
- ☐ Fit Test Performed Unsatisfactorily
- ☐ Fit Test NOT Performed at: _____
- ☐ Special prescription eyewear needed to accommodate respirator
- ☐ Special prescription eyewear needed to accommodate respirator
- ☐ Facial hair needs to be shaved to assure tight seal on certain face masks.

[1] Physician or other Licensed Healthcare Professional

[2] Employee must seek further medical evaluation by a private physician who must submit a report to _____ of his/her findings to

(Check ✓ ALL that apply)

- ☐ The above individual HAS been examined for respirator fitness in accordance with 29 CFR 1910.134. This limited evaluation is specific to respirator use only. Employees should be instructed to report any difficulties in using respirators or change of any physical status to their supervisor or physician. This evaluation included the Respiratory Questionnaire outlined in 29 CFR 1910.134.
- ☐ The above individual HAS NOT been examined by me for respirator fitness. The employee's medical evaluation consisted of a review of OSHA's Medical Evaluation Questionnaire in Appendix C Part A Section 2. In accordance with 29 CFR 1910.134, this limited evaluation is specific to respirator use only. Employees would be instructed to report any difficulties in using respirators or change of any physical status to their supervisor or physician. This evaluation included the Respiratory Questionnaire outlined in 29 CFR 1910.134.
- ☐ In accordance with specific OSHA requirements, I have informed the above named individual of the results of this evaluation and of any medical conditions resulting from exposures that may require further explanation or treatment. Where applicable, the above named individual has been informed of the increased risk of lung cancer attributable to the combined effect of smoking and asbestos, lead and/or other chemical exposure(s).

_____ Physician's Signature

_____ Physician's Name (Printed)

_____ Physician's License Number (Optional in Most States)

_____ Date of Exam

_____ Expires On

To be maintained in the employee's file with a copy to the employee