

EMPLOYER AUTHORIZATION AND INFORMATION FOR RESPIRATORY EVALUATION

EMPLOYER TO COMPLETE THE FOLLOWING:

Address: \_\_\_\_\_

Employee Name: \_\_\_\_\_

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
Continuous-Flow Respirator
Supplied-Air Respirator
Open Circuit SCBA Closed Circuit SCBA
Dust Mask 1/2 Face with Canisters Full Face with Canisters

Extent of Usage Check ✓ ALL that apply

- On a daily basis Total hours
Occasionally - but no more than 2x a wk Ttl hrs
Rarely - or for Emergency situations only Ttl hrs

Expected Physical Effort Required

- Light Moderate Heavy

Exposure to Hazardous Materials

- Arsenic Benzene
Coke Oven Cotton Seed/Dust
Cadmium Formaldehyde
Methylene Chloride Lead
Textiles Chromium
Other(s): \_\_\_\_\_

Special Work Conditions Check ALL that apply when wearing respirator

- High Places Enclosed Places Protective Clothing
Temp Extremes Mostly Cold Mostly Hot
Other: \_\_\_\_\_
Questionnaire will be: Hand Carried Mailed Other

EVALUATION AUTHORIZED BY: \_\_\_\_\_

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

PLHCP1 WRITTEN STATEMENT FOR RESPIRATORS (EMPLOYER)

PROVIDER 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 separate forms in separate 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 Highland Clinic The Workplace 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 of 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 Highland Clinic The Workplace
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 health care professional

2 Employee must seek further medical evaluation by a private physician who must submit a report of his/her findings to Highland Clinic The Workplace prior to respirator use

Check ALL that apply

- The above individual HAS been examined for respirator fitness in accordance with 29 CFR 1010.134. 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 stats to their supervisor or health care provider. This evaluation included the Respirator 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 should be instructed to report any difficulties in using respirators or change of any physical status to their supervisor or health care provider. This evaluation included the Respirator 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).

Provider's Signature

Provider's Name (Printed)

Provider's license number (optional in most states)

Date of Exam

Expires On