1 Source
Occupational Health Solutions

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Gary, IN 46406
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Respirator Medical Recommendation

(Form CCF1004)

Name:_____ **S.S.#:**_____

Company:_____ **Job Title:**_____

Based on interview, physical examination, and further evaluation as appropriate, this individual is:

☐ Medically approved for all respirator (s) including SCBA, and subject to fit test

☐ Medically approved for all respirator (s) with the exception of SCBA and subject to fit test

☐ Medically approved for only the following type subject to satisfactory fit test.

_____ Dust Mask

_____ Negative Pressure

_____ Self Contained Breathing Apparatus (SCBA)

_____ Powered Air Purifying Respirator

_____ Supplied Air

_____ Other:_____

☐ Employee may decline respirator-requiring assignment for temporary health related difficulties.

☐ Respirator assignment must not be for IDLH (immediate danger to life or health) environments.

☐ Employees should not be expected to perform rescue duty or serve as a number of a rescue team. If able to wear a respirator at the time, then rescue duties may be performed.

☐ Require further medical information / evaluation prior to qualifying for respirator use.

☐ Corrective Lenses Required

☐ Other recommendations and suggest accommodations:

_____

_____

_____

Recommended time period for next exam:

( ) Annual ( )_____

Employee has been provided with a copy of this written recommendation:

( ) Yes ( ) No

_____ _____ _____

Physician's Signature **Physician's Printed Name** **Date**