# Medical Clearance for Respirator Use

**San Mateo County Health System**

*Evaluating Entity* ___________________________________

*Reviewing Physician*_________________________________

*Address*_____________________________________________

______________________________________________________

*Phone Number:*_______________________________________

**To be Completed by Employer (Please Print):**

Respirator manufacturer ______________________ ☐ Half-face ☐ Fullface ☐ N95 Filtering Facepiece (Dust Mask)

Model:____________________ Size: ☐ S ☐ M ☐ L ☐ XL Weight of respirator __________________________

Duration and frequency of respirator use: ☐ <5 hrs/wk, ☐ <2 hrs/day, ☐ 2-4 hrs/day, ☐ >4 hrs/day

Expected physical work effort: ☐ light (<200 kcal/hr), ☐ moderate (200-350 kcal/hr), ☐ heavy (>350 kcal/hr)

Additional protective clothing and equipment to be worn: __________________________________________________

Will be working under hot conditions (temperature exceeding 77 degrees F): ☐ Yes ☐ No

Will be working under humid conditions: ☐ Yes ☐ No

**To be Completed by Employee (Please Print):**

| Name: | DOB: | Soc Sec #: XXX-XX- |
|---|---|---|
| Employer: | | Phone: |
| Type of work to be performed with respirator:<br>☐ Operations (Bulking) ☐ Hazardous Materials Emergency Response Team ☐ Health Care (Nursing Staff)<br>☐ Other (please explain) ________________________________________ | | |
| Examination: ☐ Post Offer Medical Clearance ☐ Baseline Medical Clearance ☐ Periodic Medical Clearance | | |
| Employee Status: ☐ Full Time, Permanent, Classified ☐ Extra Help ☐ Other__________________________ | | |
| Fitting Considerations: ☐ Facial Hair ☐ Glasses/Contact Lenses ☐ Dentures ☐ Facial Structure | | |

*I hereby confirm that in accordance with Cal OSHA T8CCR 5144 (Respiratory Protection),I have completed the OSHA Respirator Medical Evaluation Questionnaire (Appendix C) for a Physician or Licensed Health Care Professional (PLHCP)to review and determine if I am medically qualified to wear a respirator.*

______________________________________________________________________________

Employee (Print) Signature Date

**To be Completed by Health Care Professional (Please Print):**

I, ______________________________________________, have reviewed the OSHA Respirator Medical Evaluation Questionaire that the person mentioned on this form has provided me and have determined that he/she is:

☐ Medically Qualified for **UNRESTRICTED** use of the following respiratory protective devices:

- ☐ CATEGORY I: Self-Contained; Air-Supplied (Continuous Flow, Demand and Pressure Demand); Canister Mask; Chemical Cartridge and Mechanical Filter with and without Blower.

☐ Medically Qualified for **RESTRICTED** use of respiratory protective devices as indicated below:

- ☐ CATEGORY II:
  - ☐ Self-Contained.………………………….……1-2 hours per day
  - ☐ Air-Supplied
    - ☐ Continuous Flow…………..Unlimited
    - ☐ Demand……………………Up to 4 hours per day
    - ☐ Pressure Demand…………Up to 4 hours per day
  - ☐ Canister Mask………………………………1-2 hours per day
  - ☐ Chemical Cartridge…………………………1-2 hours per day
  - ☐ Mechanical Filter…………………………...1-2 hours per day
  - ☐ Mechanical Filter with Blower……………..Unlimited
- ☐ CATEGORY III:
  - ☐ Self-Contained.………………………….……Never
  - ☐ Air-Supplied
    - ☐ Continuous Flow………….. Emergency Only
    - ☐ Demand…………………….Emergency Only
    - ☐ Pressure Demand………….. Emergency Only
  - ☐ Canister Mask……………………………..…Never
  - ☐ Chemical Cartridge……………………….…… Never
  - ☐ Mechanical Filter…………………….……... Never
  - ☐ Mechanical Filter with Blower…………..…..Emergency Only

☐ Medically **NOT** Qualified to use any respiratory protective devices.

☐ In need of the following additional evaluation to assess qualification:________________________________

☐ In need of Medical Follow-Up Examinations as frequently as every__________________________________

*I hereby certify that in accordance with Cal OSHA T8CCR 5144 (Respiratory Protection), applicable to the use of respiratory protective equipment, I have informed the applicant/employee of the results of his/her evaluation and I have given him/her a copy of these recommendations.*

______________________________________________________________________

Health Care Professional (Print) | Signature | Date