RESPIRATOR MEDICAL CLEARANCE

Date:_______________________________________

Name: ___________________________________________ Employee ☐ Student ☐

Date of Respirator Evaluation: Reviewed Medical Evaluation Questionnaire
on____________________

This individual:

☐ Is medically qualified for use of an N, R, or P disposable particulate respirator (dust mask, non-cartridge).

☐ Is medically qualified for use of an air-purified, full-face respirator.

☐ Has the following respirator use restriction(s): ________________________________

☐ Is NOT qualified for use of a respirator.

______________________________________________
Signature of Licensed Health Care Provider

______________________________________________
Date

______________________________________________
Print name of Licensed Health Care Provider

______________________________________________
Print name of clinic/ City:

☐ Copy provided to employee/student for their files. You need to keep the signed Medical Clearance form in your files as you will need this document for your fit test.

☐ Scan and email to: occhealth@uci.edu