



Employer Respirator Evaluation Authorization

(Please print clearly)

Employer Name _____
Employee Last Name _____ First Name _____ Middle Initial _____
Social Security Number _____ - _____ - _____ Date of Birth _____
Address _____
Home / Cell Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Check Type of Respirator(s) to be Used – Check ALL that Apply

- Air-purifying (non-powered)
- Air-purifying (powered)
- Atmosphere supplying respirator
- Combo air-line & SCBA
- Continuous-Flow Respirator
- Supplied-Air Respirator
- Open Circuit SCBA
- Closed Circuit SCBA
- Dust Mask
- 1/2 Face with Canister
- Full-Face Canister
- Brand _____ Model _____ Cartridge _____

Extent of Usage – Check ALL that Apply

- On a Daily Basis _____ Total Hours
- Less than twice a week _____ Total Hours
- Rarely or for Emergencies Only _____ Total Hrs

Expected Physical Effort – Check ALL that Apply

- Light
- Moderate
- Heavy

Special Work Conditions – Check ALL that Apply

- Heights
- Enclosed Spaces
- Protective Clothing
- Temperature Extremes
- Mostly Cold
- Mostly Hot
- Other _____

Exposure to Hazardous Materials – Check ALL that Apply

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

DO NOT WRITE BELOW THIS LINE

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Physician will complete the following

- Based upon my findings, I have determined that this individual (Check All That Apply):
- Employee must schedule a medical examination prior to respirator approval and usage.
 - Class I – No restrictions on respirator use.
 - Class II – Some specific use restrictions.
 - Class III – Respirator use NOT PERMITTED.
 - Further testing / evaluation is required.
 - Fit test required.
 - Fit test performed satisfactorily.
 - Fit test performed unsatisfactorily.
 - Fit test NOT performed.
 - Special prescription eyewear needed to accommodate respirator.
 - Facial hair needs to be shaven to assure tight seal on certain face masks.

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. Employee should be instructed to report any difficulties in using respirators or changes of any physical status to their supervisor or physician. This evaluation included the Respiratory Questionnaire.

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.

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 most states)

Date of Exam

Expires On

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