

**FOR OFFICIAL USE ONLY**

**REQUEST FOR MEDICAL CLEARANCE  
FOR RESPIRATOR USE QUESTIONNAIRE**

EMPLOYEE	SSN	POSITION	
SUPERVISOR	PHONE	CODE	DEPARTMENT

**CIRCLE THE TYPE OF RESPIRATOR(S) TO BE USED:**

- |                              |  |
|------------------------------|--|
| AIR-SUPPLIED (tight-fitting) | AIR-PURIFYING (powered) (tight-fitting)  |
| AIR-SUPPLIED (hooded)        | AIR-PURIFYING (powered) (hooded)   |
| OPEN-CIRCUIT SCBA            | COMBINATION AIRLINE/SCBA   |
| CLOSED-CIRCUIT SCBA          | AIR-PURIFYING (non-powered): (Specify)   |
|                              | filtering facepiece or elastomeric<br>N, P, R 95, 99, 100<br>Type chemical cartridge _____ |

**WORK EFFORT: (CIRCLE ONE)**

- Light      Moderate      Heavy      Strenuous

**EXTENT OF USAGE: (CIRCLE ONE)**

1. On a daily basis
2. Occasionally - but more than once a week
3. Rarely - or for emergency situations only

**LENGTH OF AVERAGE WORK DAY IN RESPIRATOR: \_\_\_\_\_**

**SPECIAL WORK CONDITIONS: (i.e., high places, temperature/humidity extremes, hazardous materials, other protective clothing worn, climbing, etc.)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL WRITTEN EVALUATION**

1. No restrictions on the respirators circled above
2. Respirator use with some restrictions
3. No respirator use allowed
4. Alternate respirator recommended

**Comments/Restrictions** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Routine Follow-up medical evaluation required:** (under 35)(35-45)(over 45)  
Or due to medical findings return: Date \_\_\_\_\_  
Employee has been given a copy of this recommendation.  
5 yrs 2 yrs 1 yr

Health care professional's Signature \_\_\_\_\_ Date \_\_\_\_\_

Sections 133, 1071-87, 3012, 5031, and 8012, Title 10  
USC & Exec. Order 9397 (Privacy Act of 1974) Apply