Respirator Medical Recommendation Form

Employee name: _____

Agency name: _____

This form outlines the results of the Occupational Safety and Health Administration (OSHA) Respirator Medical Evaluation. If you have any questions regarding this evaluation please call *(fill in your county health department name and number here. You can refer their questions to this person).*

This form must be completed by a licensed medical provider.

Based on review of the OSHA Respirator Medical Evaluation Questionnaire (Mandatory) this individual is:

_____ Medically approved for all respirators, with the exception of SCBA, and subject to fit test.

_____ Not approved for respirator use at this time. Follow-up medical evaluation is needed.

Date: _____

Signature: _____

MINNESOTA MDH DEPARTMENT of HEALTH

Infectious Disease Epidemiology, Prevention and Control
612-676-5414 – TDD/TTY 651-215-8980 – www.health.state.mn.us
If you require this document in another format, such as large print, please call 612-676-5414.

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