

MEDICAL RECOMMENDATION

If you do not have a [Respiratory Protection] Program Administrator, your Supervisor should complete Part 1.

PART 1. WORKING ENVIRONMENT (to be completed by Program Administrator)

Employee Name: Mickey Mouse

Workload: [X] Light\* [ ] Moderate\* [ ] Heavy/Strenuous\*

Light: <200 kcal per hr.; sitting while writing, typing, drafting; performing light assembly work; walking level carrying up to 10 lbs. Moderate: 200-350 kcal per hr.; frequent lifting up to 25 lbs.; infrequent lifting up to 50 lbs.; walking level carrying 25 lbs. Heavy: >350 kcal per hr.; frequent lifting of 50 lbs.; infrequent lifting of 100 lbs.; walking level carrying 50 lbs.; walking uphill @ 2mph.

Usage: [ ] Frequent (>5hrs/week) [X] Occasional (<5hrs/wk.) [ ] Rare (<5hrs/month) (or emergency use only)

Will the user be working under hot conditions (i.e., temperature exceeding 77° F)? Yes/No

Will the user be working under high humidity conditions? Yes/No

Other protective gear to be worn with respirator: Disposable gloves, Protective Gown, Face Shield

Hazards to be protected against (e.g., biologicals, dusts, mists, sprays, fumes, gases, vapors): Biologicals (Infectious aerosols)

Type of respirator(s) to be assigned: [X] Filtering Face Piece respirator [ ] Half-face air purifying respirator [ ] Full-face air purifying respirator [ ] SCBA or Airline respirator [ ] PAPR (loose fitting hood or headcover) [ ] PAPR (tight-fitting)

Special Considerations: None

PART 2. MEDICAL RECOMMENDATION

(to be completed by a physician or other licensed healthcare professional (PLHCP))

- [ ] This person can wear a respirator of the type(s) described above, without restrictions. [ ] This person can wear a respirator subject to the following restrictions or limitations: [ ] This person cannot use a respirator of the type(s) described above. (If a negative-pressure respirator cannot be used, can the person use a PAPR? Yes/No) [ ] A follow-up medical evaluation is required. Employee has been referred to:

I have provided the employee named above with a copy of this recommendation.

PLHCP (Name) / (Signature) Date

NOTE: The PLHCP must review the OSHA Medical Questionnaire form as he or she completes Part 2 and determines if the individual is to be medically cleared to wear a respirator.