



Employer _____ Job Title(s) _____

Authorized by _____ Phone _____ Email _____

Respirator clearance is provided in accordance with OSHA R 1910.134. The information below must be provided along with the employee's OSHA Respirator Questionnaire in order to determine if the employee is cleared for respirator fit testing. Additional screening and/or a physical examination may be required before a determination is made.

RESPIRATOR(S) TYPE(S) TO BE USED: (Check all that apply and complete its section)

- DISPOSABLE RESPIRATOR:
 - Filter mask, non-cartridge type, dust mask
- AIR-PURIFYING RESPIRATOR, NEGATIVE PRESSURE: Mask weight _____
 - Half mask **OR** Full mask
- AIR-PURIFYING POWERED RESPIRATOR, POSITIVE PRESSURE: Mask weight _____
 - Half mask **OR** Full mask
- ATMOSPHERE-SUPPLYING RESPIRATOR: Mask weight _____
 - Self-contained (air tank, full mask) **OR**
 - Air-line: Half mask **OR** Full mask
- COMBINATION ATMOSPHERE-SUPPLYING AND AIR-PURIFYING RESPIRATOR: Mask weight _____
 - Positive pressure **OR** Negative pressure
 - Half mask **OR** Full mask



RESPIRATOR(S) HOW OFTEN/HOW LONG USED: (Check one and complete its section)

- DAILY: Hourly **OR** _____ times per shift Average time used each instance _____
- PER WEEK: _____ times per week Average time used each instance _____
- PER MONTH/RARELY: _____ times per month **OR**
 - Rarely, _____ times per _____ Average time used each instance _____
- IN EMERGENCIES ONLY (RESCUE AND ESCAPE): Average time used each instance _____

What is the maximum level of physical effort the employee is expected to perform at when wearing this respirator? (check one)

- Light Moderate Heavy Very heavy

Are there any temperature/humidity extremes the employee is expected to perform in?

- No Yes If yes, describe _____

Is there additional (other than respirator) personal protective equipment (PPE) the employee is expected to perform in?

- No Yes If yes, describe _____

Are there toxic substance(s) exposures the employee is expected to perform in?

- No Yes If yes, list substance(s) _____

Are there special work situations (i.e., high places, confined places, etc.) the employee is expected to perform in?

- No Yes If yes, describe _____

I acknowledge this form acts as both a Request and Authorization to provide clearance for Respirator Fit Testing.



Authorizing signature _____ Date _____

DO NOT MARK BELOW THIS LINE BARCODE ZONE DO NOT MARK BELOW THIS LINE



Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.