**COUNTY OF LOS ANGELES**
**DEPARTMENT OF HUMAN RESOURCES**
**OCCUPATIONAL HEALTH PROGRAMS**

# EMPLOYEE MEDICAL EVALUATION CLEARANCE FORM FOR RESPIRATOR USE

**Instructions to Department**: As the employer, you (and not the employee) are required to complete the following information needed by the OHP Reviewing Physician pertaining to the employee's identity and expected respirator use. Please type or use black ink and print legibly. Attach this form to the front of the confidential RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE, and instruct the employee to complete the questionnaire and to mail both documents to OHP, 3333 Wilshire Boulevard, 10th Floor, Los Angeles, CA 90010.

Employee Name (Last, First M.I.): _____ Employee#: _____
Department/Unit Location: _____ Job Title: _____ Hire Date:_____

1. Type and weight of respirator to be used:_____
2. Duration and frequency of respirator use (including use for rescue and escape):_____
3. Expected work effort of employee (please circle): Light Moderate Heavy
4. Additional protective clothing and equipment employee will wear with respirator:_____
5. Temperature (>77 F") and/or humidity extremes employee may encounter:_____
6. Will employee work at high altitudes (over 5,000 feet) or in a place with lower than normal oxygen? Yes ____ No _____
7. Hazardous exposures expected (please specify reason for respirator):_____
8. Type of work employee will be doing using respirator:_____

***Supervisor providing this information**:*

_____

| ***Supervisors Signature*** | ***Name (Please Print)*** | ***Title*** | ***Phone No.*** | ***Date Signed*** |
|---|---|---|---|---|

**********SECTION BELOW FOR OHP USE ONLY (Do Not Tear Off)**********

**TO THE EMPLOYEE'S DEPARTMENT:**

**Physician's Written Recommendation For Respirator Use**

1. Is this employee medically able to use the respirator? Yes _____ No _____

   If yes, any limitations on respirator use related to the medical condition of the employee or relating to the workplace conditions in which the respirator will be used:

   None _____ Other _____

2. Does this employee need follow-up medical evaluation? No _____ Yes _____
3. A copy of this written recommendation for the employee is provided (attached).

_____

*Signature of OHP Reviewing Physician* *Date Signed* *Date OHP Mailed to Department*

**STOP!** Do not complete the rest of this form unless signed by the OHP Physician. **The department is responsible for giving the copy to the employee and is advised to obtain employee signature of receipt.**

Date Dept gave copy to employee _____ By (Initial or Sign) _____