**Medical Recommendation**

**PART 1. WORKING ENVIRONMENT**

*(to be completed by Program Administrator)*

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Workload: ❒ 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) ❒ Occasional (<5hrs/wk.) ❒ Rare (<5hrs/month)

(or emergency use only)

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

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

Other protective gear to be worn with respirator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hazards to be protected against (e.g., biologicals, dusts, mists, sprays, fumes, gases, vapors): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of respirator(s) to be assigned: \_\_\_\_\_ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.

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*PLHCP (Name) (Signature)* *Date*