UNIVERSITY OF SOUTH FLORIDA
REQUEST FOR MEDICAL CLEARANCE FOR RESPIRATOR USE

Name: EID#: Date of Birth:

Position (Title): Supervisor:

Department: Campus:

Work Phone:

Check Type(s) of Respirator(s) to be used:

☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only)

☐ Half-mask air purifying respirator (non-powered) ☐ Full-facepiece air purifying respirator (non-powered)

☐ Other respirator, specify type:

Check Level of Work Effort While Wearing Respirator:

☐ Light ☐ Medium ☐ Heavy

Check Extent of Respirator Use:

☐ Daily ☐ Occasionally, but more than once a week ☐ Rarely or for emergency use only

Typical Length of Respirator Use in Hours/Minutes:_____/_____

Special work considerations (i.e., high places, temperature, humidity, hazardous materials, protective clothing, etc.):

_____ _____

Supervisor's Signature Date

Physician's / Licensed Healthcare Professional's Statement

The employee (check only one):

☐ Requires further medical evaluation

☐ May use respirator(s) without restrictions

☐ May use respirator(s) with restrictions (see below)

☐ May not use respirator(s)

Restrictions (if any):

_____ _____

Signature of Physician / Other Licensed Healthcare Professional Date

Return completed form to USF Environmental Health & Safety at ehs@usf.edu