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