**GUNDERSEN**
**HEALTH SYSTEM®**
La Crosse, WI 54601

Occupational Health Services • Mail Stop FB0-002
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# Medical Determination for Respirator Use
## 29 CFR 1910.134 - 1910.139 - 1926.103

Employee Name: _____ Company Name: _____
Address _____ Address _____
City_____ State___ Zip Code _____ City_____ State___ Zip Code _____
Phone_____ Birthdate _____ Phone_____ Fax _____
Job Title _____

## ****COMPANY MUST COMPLETE THIS SECTION****

**Please list all of the hazards for which the respirator is used for:** _____

_____

**(e) (5) (A)** **Type of Respirator:**

| | | |
|---|---|---|
| ☐ Dust Mask (Filtering Facepiece) ☐ | Resp. Wt._____ | Clinic Use only |
| ☐ Air purifying, half face with cartridge/canister | Resp. Wt._____ | |
| ☐ Air purifying, full face with cartridge/canister | Resp. Wt._____ | Exam _____ |
| ☐ Self contained breathing apparatus (SCBA) | Resp. Wt._____ | PFT _____ |
| ☐ Airline (supplied air) ☐ PAPR | Resp. Wt._____ | |
| ☐ Airline (supplied air) with a Hood | Resp. Wt._____ | |

**(e) (5) (B)** **Duration and frequency respirator required to be worn:**

☐ Daily basis ☐ hours per day: _____
☐ Occasionally, but more than once a week
☐ Rarely, or for emergency situations only

**(e) (5) (i) (C)** **Expected physical work effort while wearing a respirator:**

☐ Light (e.g. desk job)
☐ Moderate (e.g. assembly line duties)
☐ Heavy (e.g. tunnel/scaffold work)
☐ Strenuous (e.g. structural fire fighting)

**(e) (5) (i) (D)** **Check other personal protective equipment to be worn at same time as respirator:**

| | |
|---|---|
| ☐ Hearing protection | ☐ Protective coat/pants Wt. _____ |
| ☐ Safety glasses/goggles | ☐ Helmet/Hood Wt. _____ |
| ☐ Hard Had | ☐ Footwear Wt. _____ |
| ☐ Harnesses/belts Wt._____ | ☐ Other (describe): _____ |
| ☐ Gloves/guantlets Wt._____ | _____ |
| ☐ Impervious Clothing (e.g. Tyvek, vapor suits, etc.) | _____ |

Total weight, in pounds, all other PPE worn at same time as respirator - Total Wt._____

**(e) (5) (i) (E)** **Extremes of : Temperature** from _____ F to _____ F
**Humidity** from _____ % to _____ %

## *Physician/Licensed Health Care Professional (PLHCP) Medical Determination for Respirator Use*

**(e) (6) (i)**

_____ **Medically able to use a respirator. No restriction on use of the types of respirators identified above.**
_____ **Not medically able to use the respirators identified above.**
_____ **Specific limitations on respirator use due to medical or workplace conditions, as stated below:**

**Restriction:**_____

_____

_____ **Medical hold until: _____; awaiting more data or follow-up evaluation**_____

**Re-Evaluation is indicated: ☐ Within the next _____ months ☐ in _____ years**
**☐ By Questionnaire ☐ By Examination**

**The employee has been provided with a copy of these written recommendations.**

**PLHCP's Name (Print)**_____ **Signature**_____ **Date**_____
**Address** _____