**********Employee Complete TOP Section Only**********

Job Title/Dept/Supervisor: _____ **ASU ID:** _____

Appalachian State University Respiratory Protection Program

MEDICAL APPROVAL FOR ***NON-ASBESTOS*** RESPIRATOR USE

Employee Full Name: _____

Date of Birth: _____ Daytime Phone: _____

Respirator Type: Check the type(s) of respirator(s) that will be worn:

Disposable Dust Mask (negative-pressure air purifying)	½-Face Mask (negative-pressure air purifying)	Full-Face Mask (negative-pressure air purifying)	Powered Air- Purifying Respirator (PAPR) (positive pressure)	Supplied Air (Airline or SCBA) (positive pressure or pressure-demand)
 ☐	 ☐	 ☐	 ☐	 ☐
Approx wt: 1 oz.	Approx wt: 1 Lb.	Approx wt: 2 Lbs.	Approx wt: 6 lbs w/out Helmet	Approx wt: Airline – 5lbs SCBA – 30 lbs.

Hrs used per day: _____ **Days used per mo**: _____

Work Effort:
- ☐ **Hard** (hot &/or heavy work; e.g. confined space entry)
- ☐ **Medium** (walking/standing, occasional lifting/heavy; e.g. painting, welding in comfortable position)
- ☐ **Light** (sitting, occasional walking/lifting; e.g. soldering)

Temp/Humidity extremes encountered while wearing respirator? (Yes/No & Describe) _____

Additional PPE worn while wearing respirator? (None or List all) _____

**********Physician, PA, or Nurse Practitioner (PLHCP) complete below**********

Employee Full Name: _____

Date of Evaluation: _____ **PLHCP Performing Evaluation** _____

Based on respirator usage conditions described on the reverse side and on my medical evaluation of this employee, my medical opinion is as follows (check **one**):

- ☐ This employee may wear a respirator without conditions.
- ☐ This employee may wear a respirator, but **only** the following kind(s):_____.
- ☐ This employee may wear a respirator, but with these **restrictions**: _____.
- ☐ This employee may wear a respirator **if corrective lenses** are included.
- ☐ This employee may **not** wear a respirator.

Are follow-up medical evaluation(s) required? ☐ **YES** ☐ **NO.**

If YES, indicate interval for required follow-up:

☐ Every Year. ☐ One-time follow-up in ☐ months. Other (Specify) _____.

This medical evaluation was based on **(check applicable evaluation type):**

- ☐ Questionnaire only
- ☐ Questionnaire & Physical Examination ***without*** PFT
- ☐ Questionnaire, Physical Exam, & PFT
- ☐ Questionnaire, Physical Exam, PFT, & Other (specify) _____

PLHCP & Practice Name: _____

PLHCP Signature: _____ **Signature Date:** _____

Please return this form, *not the Questionnaire,* to Debi Trivette, ASU EHS&EM Office

Updated 11/20/2014