Medical Evaluation of Fitness for Respirator Use

To be completed by the **Field Station**:

Employee Name: ________________________________
Duty Station: ___________________________________
Supervisor/Point of Contact: _______________________ Phone: ___________________
Medical Questionnaire Completed? YES/NO

To be completed by the **Physician**:

I have, according to Federal Standard 29 CFR 1910.134, physically examined and/or reviewed the pertinent medical data of ______________________________ and determined the employee:

- ☐ Can wear a NIOSH approved ___ negative or ___ positive pressure respirator without producing cardiopulmonary stress dangerous to his/her health.
- ☐ Can wear a NIOSH approved ____ negative or ____ positive pressure respirator subject to the following limitations: _________________________________
  ____
  ____
- ☐ Cannot wear a NIOSH approved negative or positive pressure respirator without producing cardiopulmonary stress dangerous to his/her health.
- ☐ Based on review of the medical questionnaire, further medical evaluations are necessary.

Notes:____
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Provide a copy of this form to the employee or supervisor listed above.

____________________	____
Date	Signature, Examining Physician

____________________________ ______________________________
Print Physician's Name and Address

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FWS Form 3-2364
05/08