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Title:	Respirator Medical Clearance Verification Form
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Los Alamos NATIONAL LABORATORY

Respirator Medical Clearance Verification Form

Project Name: _____

Subcontractor #: _____ **Prime Subcontractor Name:** _____

SECTION I – EMPLOYEE INFORMATION		
Employee Name:	ID / Z #:	Date:
Subcontractor Supervisor Name and Z#:		

SECTION II – MEDICAL CLEARANCE DETERMINATION

☐ **Yes** – The employee is medically cleared to wear a tight-fitting respirator.

☐ **No** – The employee is *not* medically cleared to wear a tight-fitting respirator.

(If "No," the employee must not participate in fit testing or respirator use until cleared by a licensed healthcare professional (LHCP).)

SECTION III – CLINICIAN CERTIFICATION

I certify that the above employee has been evaluated in accordance with **OSHA 29 CFR 1910.134** and this determination represents my medical opinion.

LHCP Name/Z#: _____ Signature: _____ Date: _____

Clinic / Provider Name: _____ Phone #: _____

Clinic / Provider Address: _____

_____

Please submit to the respiratorteam@lanl.gov and copy the STR.