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Title: Respirator Medical Clearance Verification Form

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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.