Respiratory Protection Plan - Form 1: Medical Clearance Request for Respirator User

Employee Information	
Name:	DOB:
Email:	Phone:
Portland Community College (PCC)	
Campus:	Department:
Supervisor Name:	Signature:

Check Respirator Type(s) to be Used	
Disposable Face Mask	
Air-Purifying Half-Face Respirator	
Air-Purifying Full-Face Respirator	
Powered Air Purifying Respirator	
Air Line Respirator	
Self-Contained Breathing Apparatus	

Nature of Task(s) Performed	
Process(es):	
Contaminant(s) Generated: Dust _____ Mist _____ Fume _____ Fiber_____ Gas _____Vapor _____Smoke _____ Rad _____ Bio _____	
Work Level Associated with Task: Light _____Moderate _____Heavy_____	
Duration (hrs/day):_____	Frequency (days/mo): _____
Other Personal Protective Equipment Worn:	
Special Consideration (extreme temps, elevations, haz mat, hazardous process):	

Physician's (PLHCP) Evaluation		
Check Applicable Box		1. No restrictions on respirator use
		2. Specific use restrictions
		3. No respirator use permitted
Explanation:		
PLHCP Name: _____		PLHCP Signature: _____
Evaluation Date: _____		Next Evaluation Due: _____