**ANNUAL RESPIRATOR MEDICAL ASSESSMENT AND CLEARANCE FORM**

**Please complete this form by typing directly into the fillable text control. Completed form should be emailed directly to** **tebehaevuo15@ecu.edu****; you do not have to print this form please.**

Last Name: Click here to enter text. First Name: Click here to enter text.

Department: Click here to enter text. Job Title: Click here to enter text.

Supervisor: Click here to enter text. Email: Click here to enter text.

**Please check as relevant**:

[ ]  I have had signs or symptoms (such as shortness of breath, dizziness, chest pains, or wheezing etc.) for the past one year that affects my ability to use a respirator.

I have had changes in my health as it relates to smoking [ ]  medication [ ]  pulmonary [ ]  cardiac [ ]  blood pressure [ ]  or other health changes [ ]

[ ]  The Office of Prospective Health or a Licensed Health Care Professional (PLHCP) recommended a re-evaluation during my last medical evaluation.

[ ]  I have observed a medical problem that impedes my ability to use a respirator.

[ ]  Changes (such as physical work effort, type of respirator used, protective clothing, temperature etc.) have occurred in my office or workplace which have increased physiological burden for me to use a respirator.

[ ]  None of these apply to me; since my last fit test, there have been no significant changes in my health status.

**Employee** **Signature** (Initial): Click here to enter text. **Date** Click here to enter a date.

**For EH&S Use**

Recommended for medical re-evaluation Yes [ ]  No [ ]

Approved for fit test with hazard assessment Yes [ ]  No [ ]

Approved for fit test without restrictions Yes [ ]  No [ ]

Other Comments: Click here to enter text.