**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**](mailto: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.