Dept/Job Title: _____ **ASU Username:** _____

Appalachian State University Respiratory Protection Program

MEDICAL APPROVAL FOR RESPIRATOR USE FOR ASBESTOS-EXPOSED EMPLOYEES

Information for Employee to Provide to Physician

Instructions for Employee:

(1) Please complete ALL information on this side.
(2) Give this page to the physician at your medical evaluation.
(3) If you wish to save the form, save as filename "MedApprvl_ASB_LastnameFirstname.pdf"
(4) The physician will complete the other side and send the completed form back to ASU.

Employee Full Name: _____

Date of Birth: _____

Daytime Phone: _____

Respirator Type: Circle the type(s) of respirator(s) that will be worn:

¾-Face Mask (negative-pressure air	Full-Face Mask (negative-pressure air	Powered Air- Purifying Respirator (PAPR) (positive pressure)	Supplied Air (Airline or SCBA) (positive pressure or pressure-
 ☐	 ☐	 ☐	 ☐
Approx wt: 1 lbs.	Approx wt: 2 lbs.	Approx wt: 6 lbs not incl helmet.	Approx wt: Airline - 5lbs SCBA - 30 lbs

Hrs used per day: _____

Days used per mo: _____

Work Effort:

☐ **Hard** (hot &/or heavy work; e.g. confined space entry)

☐ **Medium** (walking/standing, occasional lifting/heavy; e.g. painting, welding in comfortable position)

☐ **Light** (sitting, occasional walking/lifting; e.g. soldering)

Temperature extremes encountered while wearing respirator? ☐ **Yes** ☐ **No**

Humidity extremes encountered while wearing respirator? ☐ **Yes** ☐ **No**

Additional PPE worn while wearing respirator (list all)? _____

_____

Appalachian State University Respiratory Protection Program

MEDICAL APPROVAL FOR ASBESTOS WORK & RESPIRATOR USE

Information for Physician to Provide to ASU

Instructions for Physician:

(1) Please review information on other side before performing medical evaluation.
(2) Complete this form.
(3) If you wish to email the form, save as filename "MedApprvl_ASB_LastnameFirstname.pdf"
(4) Mail ONLY this completed form to Ms. Debi Trivette, ASU EHS&EM Office, ASU Box 32112, Boone NC 28606-2112. (email trivettedp@appstate.edu; FAX 262-6914).

Employee Name: _____

Date of Medical Evaluation: _____ **ASU Username:** _____

I have completed a medical evaluation of the above-stated employee in accordance with OSHA, 40 CFR 1926.134 (*Respiratory Protection*) and 1910.1001 (*Asbestos*).

Based on respiratory usage conditions described on the reverse side and on my medical evaluation of this employee, my medical opinion is as follows (check one):

- ☐ This employee may wear a respirator without restrictions.
- ☐ This employee may wear a respirator, but **only** the following kind(s):_____.
- ☐ This employee may wear a respirator, but with the following **restrictions**: _____.
- ☐ This employee may wear a respirator if corrective lenses are included.
- ☐ This employee may **not** wear a respirator.

I have explained to the employee that **followup medical evaluations are required** at **least annually** due to his/her work with asbestos.

I ☐ ***have*** ☐ ***have not*** *[mark one]* detected any medical conditions that would place the employee at an increased risk of material health impairment from exposure to asbestos.

_____ *[initial]* I have counseled that employee about the increased health risk of asbestos-related lung disease in persons who smoke.

_____ *[initial]* I have informed the employee of the results of the medical examination and any medical conditions that may result from asbestos exposure.

This medical evaluation was based on (check all that apply):

- ☐ Employee's answers on written questionnaire
- ☐ Physical exam (☐ with PFT ☐ without PFT) (☐ with chest X-ray ☐ without X-ray)

Examining & Reviewing MD Name(s):_____

Examining MD Signature & Date: