Medical Recommendation Form

On ______________________, I evaluated ___________________________________

Date: ____________ Patient's name:____

At this time there (are)/(are not) medical contraindications to the employee named above wearing a respirator while working in potential pesticide exposure environments. The patient (does)/(does not) require further medical evaluation at this time. Any restrictions to wearing a respirator or to the type of respiratory protection are given below.

____

____

____

____

I have provided the above-named patient with a copy of this form.

___________________________________ ___________________
Physician's Signature Date

____
Physician's Printed Name

NOTE: *A PHYSICIAN OR OTHER LICENSED HEALTH CARE PROFESSIONAL'S REPORT OF EVALUATION AND APPROVAL FOR USE MUST BE ON FILE WITH THE EMPLOYER BEFORE WORK REQUIRING RESPIRATOR USE IS ALLOWED.*