

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

Employee Information	
Name:	DOB:
Email:	Phone:
Portland Community College (PCC)	
Campus:	Department:
Manager Name:	Signature:
Check Respirator Type(s) to be Used	
Disposable Face Mask	<input type="checkbox"/>
Air-Purifying Half-Face Respirator	<input type="checkbox"/>
Air-Purifying Full-Face Respirator	<input type="checkbox"/>
Powered Air Purifying Respirator	<input type="checkbox"/>
Air Line Respirator	<input type="checkbox"/>
Self-Contained Breathing Apparatus	<input type="checkbox"/>
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	<input type="checkbox"/> 1. No restrictions on respirator use
	<input type="checkbox"/> 2. Specific use restrictions
	<input type="checkbox"/> 3. No respirator use permitted
Explanation:	
PLHCP Name: _____	PLHCP Signature: _____
Evaluation Date: _____	Next Evaluation Due: _____