

U.S. ARMY CORPS OF ENGINEERS - NEW ORLEANS DISTRICT  
RESPIRATOR MEDICAL CLEARANCE

Name:	Date of Birth:
Crew:	Office Symbol:

PART I - TO BE FILLED OUT BY SUPERVISOR

A. CHECK TYPE OR TYPES OF RESPIRATOR(S) TO BE USED:

<input type="checkbox"/>	Half-face Air-purifying cartridge	<input type="checkbox"/>	Full-face cartridge
<input type="checkbox"/>	Full-face Powered Air-supply	<input type="checkbox"/>	Self-contained (Scott Air)

B. LEVEL OF WORK EFFORT (CHECK ONE):

<input type="checkbox"/>	Light	<input type="checkbox"/>	Moderate
<input type="checkbox"/>	Heavy	<input type="checkbox"/>	Strenuous

C. Extent of Usage:

<input type="checkbox"/>	Daily	<input type="checkbox"/>	Weekly, average number hours per week
<input type="checkbox"/>	Rarely -- or for emergency situations only		

D. SPECIAL WORK CONSIDERATIONS (CHECK ALL THAT APPLY):

<input type="checkbox"/>	High Places	<input type="checkbox"/>	Protective Clothing
<input type="checkbox"/>	Elevated Temperatures	<input type="checkbox"/>	Confined Spaces
<input type="checkbox"/>	Hazardous Material	<input type="checkbox"/>	Other (Specify)
<input type="checkbox"/>	Approximate weight of respirator equipment (pounds)		

Supervisor's Signature

PART II - TO BE FILLED OUT BY EMPLOYEE

Have you had, or do you now have any of the following	No	Yes	Examiner's Comments
Used a half-face respirator	<input type="checkbox"/>	<input type="checkbox"/>	
History of fainting spells or unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Fear of tight or enclosed places	<input type="checkbox"/>	<input type="checkbox"/>	
Sensation of smothering	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Heat exhaustion or stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Ruptured ear drum	<input type="checkbox"/>	<input type="checkbox"/>	
Contact lenses or glasses	<input type="checkbox"/>	<input type="checkbox"/>	

Dentures			
Facial scars which would restrict the fitting and or wearing of a respirator			
If you have any other problems which you feel might interfere with your ability to wear a respirator, please enter them here and mention them to the examiner.			Employee's Signature and date

**PART III - TO BE FILLED OUT BY EXAMINER**

**A. I HAVE REVIEWED THE FOLLOWING INFORMATION:**

	Review of Medical Examination performed on _____ (date); copy attached
	Review of Respirator Medical and other pertinent history questionnaires
	FEOH Laboratory Profile (where clinically indicated)
	Pulmonary Function Test (FVC and FEV 1)
	Other tests performed and reviewed
<b>B.</b>	<b>I CERTIFY THAT, BASED ON THIS REVIEW, THE EMPLOYEE IS CLASSIFIED IN THE FOLLOWING REPIRATOR CATEGORY:</b>
	No restrictions on respirator use
	Some specific-use restrictions
	No respirator use permitted

Restrictions:

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Examiner:

Date:

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