

CLEARANCE FOR RPE/PPE USE

WDC/PBCDF Medical Department

Name:		SSN:		Date		
Date of Birth:	Height: Ft.	Inches	Weight: lbs.	Sex:	M:	F:
Job Title:			Employer: Washing Demilitarization Company			
Check All That Apply	Type of Respirator to be Used	Optical Inserts Required (Check One):		Yes	NO	
		Level of Work	Check One	Extent of Usage	Check One	
	½ Face/full face negative pressure air purifying (includes Military Gas Mask)	Light		Daily Basis		
	Powered air purifying respirator	Moderate		Occasionally		
	Supplied air respirator (Airline/SCBA/DPE with backpack apparatus)	Heavy		Rarely		
	Emergency Escape Device	Strenuous		Emergency Escape		
	Other (list):					
Special Work Considerations (i.e., high places, temperature, protective clothing, etc.):			Length of Time of Anticipated Effort, in Hours:			
			Employer Representative Printed Name & Signature			

Medical Screener Evaluation	Check One	Medical Screener		
Individual is cleared to wear RPE/PPE		Name (typed/printed)	Title	Signature
Individual needs further medical evaluation				

Written Recommendation for Use of Protective Devices

I have reviewed or completed the medical evaluation of _____ for the use of the RPE/PPE device(s) listed above and in compliance with OSHA Respirator Standard 29 CFR 1910.134, effective 8 April 1998. Based upon my review or evaluation, I find that this individual *is / is not* (circle one) able to wear these device(s) in a safe and healthful manner. I *have / have not* (circle one) identified the following limitations on the use of the above selected respirators:

In my judgment, this individual *does / does not* (circle one) require a follow-up medical examination to make a final determination as to the ability to wear the protective devices listed above.

The individual named above has been provided with a copy of this written recommendation and has been advised to request a follow-up medical evaluation if *she/ he* develops medical signs or symptoms which impair *her/his* ability to safely use this respiratory protective device as intended.

Printed Name & Title of Licensed Healthcare Professional: _____ Signature: _____

STATEMENT REQUIRED BY PRIVACY ACT OF 1974:

Authority: 5 USC 552a, 29 CFR 1910.134 and TB MED 502, DLAM 1000.2, paragraph 2-10.

Principal Purpose: A statement for personal identification of Washington Demilitarization Company Pine Bluff Chemical Demilitarization Facility employees for medical evaluation to determine physical and physiological capability to perform work while wearing prescribed respiratory protection.

Routine Uses: Disclosure of information herein contained may be provided to proper authorities in actions regarding law enforcement, legal actions as a result of death, personal injury or damages to property and investigation of accidents arising in or out of the wear or use of prescribed respiratory protection.

Mandatory or Voluntary Disclosure and Effect on Individual Not Providing Information: Disclosure is voluntary. Failure to complete the form will disqualify the participant from participating in any and all activities associated with ear or use of prescribed respiratory protection.

X Individual's signature: _____

WDC/PBCDF Medical Department - Respirator Training and Fit Testing		Respiratory Specialist
Name:	<i>Training and Fit Testing:</i> This individual has been trained and fitted to use the following Respiratory Protective Equipment (RPE) Individuals requiring prescription lens inserts have been fit-tested with functional inserts in place.	
Work Place:		
AIR PURIFYING RESPIRATORS		
TYPE	MANUFACTURER	SIZE
FULL FACE		
HALF FACE		
PROTECTIVE MASK TYPE		
PAPR		
AIR LINE RESPIRATORS		
TYPE	MANUFACTURER	SIZE
FACE PIECE		
HOOD		
SELF-CONTAINED BREATHING APPARATUSES		
TYPE	MANUFACTURER	SIZE
FACE PIECE		
HOOD		
EMERGENCY ESCAPE DEVICE		
FITTING TEST METHOD (Check One):	Quantitative _____ Qualitative _____	
RESULTS	INDUSTRIAL RPE TRAINING & FITTING AUTHORITY: SIGNATURE REQUIRED _____	
PASS:		
FAIL:		
Protection Factor:		
REMARKS:		
FITTING TEST METHOD (Check One):	Quantitative _____ Qualitative _____	
RESULTS	MILITARY RPE TRAINING & FITTING AUTHORITY: SIGNATURE REQUIRED _____	
PASS:		
FAIL:		
Protection Factor:		
REMARKS:		
User's Statement: I, the undersigned, have been medically evaluated, trained, and fitted to use the respiratory Protection Equipment indicated above and issued to me:		
_____ User's Signature & date signed		