Bridgestone Aiken PSR

Respirator Medical Determination Form

Patient Name: _____ Evaluation Date: _____

DOB: _____ SSN: _____

Job Title: _____

Exam Results:

Is there a need for further evaluation based on the Respirator Evaluation History? YES / NO

If YES, Please explain: _____

_____

_____

_____

Are there any limitations on respirator use? YES / NO

If YES, Please explain: _____

_____

_____

_____

Pulmonary Functions Test PASS / FAIL

___ Patient is cleared to wear a respirator without restriction.

___ Patient is cleared to wear a respirator with restriction: _____

_____

___ Patient is **NOT** cleared to wear a respirator: _____

_____

Medical Professional Signature: _____ Date: _____

Patient signature below acknowledging they have reviewed this information and received a copy for their records:

Patient Signature: _____ Date: _____