Physician or Other Licensed Health Care Professional Approval Form

AIC Health and Safety Committee

To be completed after review of the OSHA Respirator Medical Evaluation Questionnaire (Mandatory) Appendix C to Sec. 1910.134

To be completed by the Conservator:

1. Conservator's name:____

2. Address:____

3. City/State/Zip:____

4. Telephone:____

To be completed by the Physician or Other Licensed Health Care Professional:

I have reviewed the form: OSHA Respirator Medical Evaluation Questionnaire (Mandatory) Appendix C to Sec. 1910.134.

The above identified individual is approved to wear a respirator? (yes)________ (no)__________

If yes, when does approval expire? (date for re-exam)________________________

Physician or Other Licensed Health Care Professional:

1. Name:____

2. Signature:____

3. Date:____

This completed and signed form must be provided by the conservator before the AIC Health and Safety Committee will conduct respirator fit testing.