

Montgomery County
Office of Human Resources
Occupational Medical Services

Medical Determination of Readiness for Respirator Fit-Testing Form

Employee Name: _____ SS#: _____

Department: _____ Position: _____

To the Health Care Provider completing this form, check the appropriate items below:

_____ I certify that I have reviewed the 'Medical History Form for Assessing Readiness For Respirator Mask Fitting Form'

After completing the review of the above form, I certify:

_____ The above named employee has been medically certified to wear a positive pressure self-contained breathing apparatus pending successful fit testing.

_____ The above named employee is not cleared for wearing a respirator at this time. Further medical evaluation is necessary to make a final determination.

_____ The above named employee may wear a negative pressure breathing apparatus with a tight full fit face piece pending successful fit testing.

_____ The above named employee is not recommended for any respirator use.

_____ The employee has been provided with a copy of this form.

The 'Medical History Form for Assessing Readiness For Respirator Mask Fitting Form' has been:

_____ Filed in the employee's Occupational Medical Services medical record

_____ Returned to the employee for his/her personal records

Employee Medical Examiner/other Provider Printed Name

Provider's Signature

Date of Signature