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

Dept. – White
Employee – Yellow
Employee Medical Record - Pink