University of Kansas
Respiratory Protection Program

Employee Medical Qualification/Evaluation Form

1) Employee: _____
2) Job Title: _____
3) Campus Unit: _____
4) Date of Last Respirator Physical: _____

5) Examining Physician/Health Care Professional

_____	_____	_____
Name	Title	Phone

6) Was a pulmonary function test administered to this employee? **YES** **NO**
If yes, summarize results:

7) In your opinion, is this employee medically capable to use a respirator? **YES** **NO**

Please provide any written recommendation/comments regarding employee's ability to use a respirator.

8) Please identify any limitations on respirator use related to the medical condition of the employee, or relating to workplace conditions in which the respirator will be used.

9) Please identify the need, if any, for follow-up medical evaluations

10) Please feel free to provide additional information/comments that you believe are pertinent so that we may successfully provide our employee with the appropriate respiratory protection.

Medical Signature: _____ Title: _____ Date: _____

KU-EHS Dept Review By: _____Title: _____ Date: _____

* Employee is to provide a copy of this page to KU-EHS Dept. at time of respirator fit testing.

For Questions regarding this form, contact the KU-EHS Dept at 864-2854.