

**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.