UNIVERSITY OF WYOMING

**APPENDIX H**
**Medical Evaluation for Respiratory Protection Equipment Use**

| Employee Name: | Department: |
|---|---|
| Job Title: | Date respiratory protection medical evaluation questionnaire (Appendix F) was completed: |
| Describe the work environment in which the respiratory protection equipment will be used: | |
| Check the type(s) of respiratory protection the employee is approved to use:<br>☐ Filtering face piece respirator<br>☐ Half-face APR<br>☐ Full-face APR<br>☐ Loose-fitting PAPR<br>☐ Tight-fitting PAPR<br>☐ Supplied-air (compressed air)<br>☐ Supplied-air (compressor)<br>☐ SCBA | |
| List applicable limitations (if any): | |
| Describe follow-up medical evaluation (if needed): | |
| Next medical evaluation date: | |
| Name/title of physician or other licensed health care provider (PLHCP) completing this medical evaluation: | |
| Signature/Title of PLHCP completing this medical evaluation: | |
| Date: | |
| Note: Medical evaluations (including PFTs) will be completed initially. At least annually thereafter, a medical status update review will be completed and documented (Appendix G).<br>This form will be maintained with fit testing and training records. | |