PHYSICIAN'S MEDICAL EVALUATION FOR RESPIRATOR USE AND FIT TEST

To be completed by any Licensed Funeral Director or Registered Intern requesting non-mandated respirator use during embalming and the evaluating healthcare professional.

Funeral Home Name:
Employee Name *(First, Middle, Last)*:

Information Provided to Healthcare Professional

In order to provide the medical evaluation of an employee requesting the voluntary (non-mandatory) use of a respirator, the healthcare professional has received from this funeral home the following information:

Check items provided:

- ☐ Copy of the Formaldehyde Standard, 29 CFR 1910.1048.
  (Specifically, Non-mandatory medical disease questionnaire.)
- ☐ Description of the employee's duties as they relate to the use of the respirator.

Written Opinion of Healthcare Professional Following Medical Evaluation

Upon completion of the medical evaluation, the following portion of this form is to be completed and signed by the healthcare professional in accordance with OSHA Formaldehyde Standard, 29 CFR 1910.1048.

As the healthcare professional, I acknowledge that my written opinion of medical evaluation is limited to the following responses:

1. As the result of my evaluation:
   - ☐ YES, the employee has been medically cleared to use a Formaldehyde respirator.
   - ☐ NO, the employee has not been medically cleared to use a Formaldehyde respirator.
2. The above named employee has been informed by me of the results of the evaluation.
3. The above named employee has been informed by me of any medical conditions that may result from the use of a respirator. Further evaluation or treatment may be required.
4. All other findings or diagnoses shall remain confidential and not be included in the written report.

Healthcare Professional Name *(First, Middle, Last)*:	Date of Evaluation:
Healthcare Professional Address *(Street, City, State, Zip)*:	
Healthcare Professional Signature: **X**	Date:

Employees must be medically cleared PRIOR to the OSHA Compliance Officer performing a Respirator Fit Test.

Fit Testing Protocol *(See 29 CFR 1910.1048(g) and 29 CFR 1910.134 Appendix A)*

1 ☐ Available Respirators to Select from:

Type: ☐ Full Facepiece or ☐ Half Mask *(requires gas-proof goggles)* Model: _____

Manufacturer: _____ Sizes: _____

Type: ☐ Full Facepiece or ☐ Half Mask *(requires gas-proof goggles)* Model: _____

Manufacturer: _____ Sizes: _____

2 ☐ Fitting instructions and demonstration

3. ☐ Respirator Selected:

Type: ☐ Full Facepiece or ☐ Half Mask *(requires gas-proof goggles)* Model: _____

Manufacturer: _____ Sizes: _____

4. ☐ Five Minute Comfort Assessment

5. ☐ Check for Obstructions Which Could Affect Respirator:

☐ Beard Growth ☐ Long Sideburns ☐ Glasses ☐ None ☐ Other Obstructions: _____

Comments: _____

6. ☐ Fit Test Exercises shall be performed for one minute (*except grimace for 15 seconds)*:

☐ Normal Breathing *(at beginning of exercises)*
☐ Deep Breathing
☐ Turning Head Side to Side
☐ Moving Head Up and Down
☐ Talking
☐ Grimace
☐ Bending Over
☐ Normal Breathing *(at end of exercises)*

7. ☐ Fit Checks:

Positive Pressure: ☐ Pass ☐ Fail Negative Pressure: ☐ Pass ☐ Fail

8. ☐ Qualitative Fit Test

Because exposure to formaldehyde can affect the employee's ability to detect common odorants, the fit test selections shall be made appropriate to the employee being tested from one of the following OSHA approved tests:

Stannic Chloride *(irritant smoke)*:	☐ Pass	☐ Fail	☐ Not Done: _____
Isoamyl Acetate *(banana oil)*:	☐ Pass	☐ Fail	☐ Not Done: _____
Saccharine Solution *(aerosol)*:	☐ Pass	☐ Fail	☐ Not Done: _____
Denatonium Benzoate, Bitrex™ *(aerosol)*:	☐ Pass	☐ Fail	☐ Not Done: _____

Employee Acknowledgment of Healthcare Professional's Written Opinion and Confirmation of Fit Testing

I, the above named employee, acknowledge that I have received a copy of the healthcare professional's written opinion, that I have been Fit Tested for the use of the referenced respirator, and that each of the functions described have been successfully completed.

Employee Signature: X		Date:
Funeral Home Tester Name *(First, Middle, Last)*:	Funeral Home Tester Signature: X	Date:

After completion, copies of the form are distributed as follows:

A. Maintain original in Funeral Home File *(marked Confidential)*
B. Healthcare Professional keeps a photocopy.
C. Employee keeps a photocopy.