WRITTEN MEDICAL OPINION FOR EMPLOYER

EMPLOYER: ________________________________

EMPLOYEE NAME: ___________________________ DATE OF EXAMINATION: ____________

TYPE OF EXAMINATION:
[ ] Initial examination [ ] Periodic examination [ ] Specialist examination
[ ] Other: ________________________________

USE OF RESPIRATOR:
[ ] No limitations on respirator use
[ ] Recommended limitations on use of respirator: ___________________________________________

Dates for recommended limitations, if applicable: _____________ to ________________

MM/DD/YYYY       MM/DD/YYYY

The employee has provided written authorization for disclosure of the following to the employer (if applicable):

[ ] This employee should be examined by an American Board Certified Specialist in Pulmonary Disease or Occupational Medicine
[ ] Recommended limitations on exposure to respirable crystalline silica: __________________________

Dates for exposure limitations noted above: _____________ to ________________

MM/DD/YYYY       MM/DD/YYYY

NEXT PERIODIC EVALUATION: [ ] 3 years [ ] Other: ________________

MM/DD/YYYY

Examining Provider: ___________________________ Date: ____________

(signature)

Provider Name: ______________________________ Provider’s specialty: __________________________

Office Address: ______________________________ Office Phone: ________________

[ ] I attest that the results have been explained to the employee.

The following is required to be checked by the Physician or other Licensed Health Care Professional (PLHCP):
[ ] I attest that this medical examination has met the requirements of the medical surveillance section of the OSHA Respirable Crystalline Silica standard (§ 1910.1053(h) or 1926.1153(h)).