WRITTEN MEDICAL REPORT FOR EMPLOYEE

EMPLOYEE NAME: _____ **DATE OF EXAMINATION:** _____

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

[ ] Other: _____

RESULTS OF MEDICAL EXAMINATION:

Physical Examination –	[ ] Normal	[ ] Abnormal (see below)	[ ] Not performed
Chest X-Ray –	[ ] Normal	[ ] Abnormal (see below)	[ ] Not performed
Breathing Test (Spirometry) –	[ ] Normal	[ ] Abnormal (see below)	[ ] Not performed
Test for Tuberculosis –	[ ] Normal	[ ] Abnormal (see below)	[ ] Not performed
Other:_____	[ ] Normal	[ ] Abnormal (see below)	[ ] Not performed

Results reported as abnormal: _____

_____

[ ] Your health may be at increased risk from exposure to respirable crystalline silica due to the following:

_____

RECOMMENDATIONS:

[ ] No limitations on respirator use

[ ] Recommended limitations on use of respirator: _____

[ ] Recommended limitations on exposure to respirable crystalline silica: _____

_____

Dates for recommended limitations, if applicable: _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

[ ] I recommend that you be examined by a Board Certified Specialist in Pulmonary Disease or Occupational Medicine

[ ] Other recommendations*: _____

_____

Your next periodic examination for silica exposure should be in: [ ] 3 years [ ] Other: _____ (MM/DD/YYYY)

Examining Provider: _____ (signature) Date: _____

Provider Name: _____

Office Address: _____ Office Phone: _____

*These findings may not be related to respirable crystalline silica exposure or may not be work-related, and therefore may not be covered by the employer. These findings may necessitate follow-up and treatment by your personal physician. Respirable Crystalline Silica standard (§ 1910.1053 or 1926.1153)