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: _____ (MM/DD/YYYY) to _____ (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: _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

NEXT PERIODIC EVALUATION: [ ] 3 years [ ] Other: _____ (MM/DD/YYYY)

Examining Provider: _____ (signature) Date: _____

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)).