



## Initial Respirator Clearance and Enrollment Form

### Health Clearance and Initial Enrollment to the Respiratory Protection Program

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Title: \_\_\_\_\_ Employee Phone: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ eID: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_ Supervisor Phone: \_\_\_\_\_

College/Unit: \_\_\_\_\_ Department: \_\_\_\_\_

#### **Information for Employee and Supervisor**

This form must be completed *prior* to fit testing by Kansas State University (KSU). Complete the section above and only Part One of this form. Take the executed form to medical exam.

**After Part Two is completed and signed by the physician or other licensed healthcare professional (PLHCP), this document must be returned to Environmental Health and Safety (EHS) before the employee can be fit tested and approved for respirator use at KSU. If fit testing is conducted elsewhere, employee must still provide documentation of fit testing and a copy of this executed form to KSU EHS. This form must be completed in conjunction with the Respirator Medical Evaluation Questionnaire.**

**IMPORTANT:** A hazard assessment or job duty review must be completed prior to employee enrollment into the Respiratory Protection Program and selection of respirator. Contact KSU EHS 785-532-5856 for information.

#### **Information for Occupational Health Care Provider**

The KSU employee being medically evaluated will/may be required to wear respiratory protection in the execution of their work responsibilities. Following your assessment of the employee's fitness for respirator use (in accordance with the OSHA Respiratory Protection Standard 29 CFR 1910.134), please complete Part Two of this form, indicating if the employee is medically cleared to wear the respirator(s) identified/checked below under the conditions identified herein (Part One) and return the signed form to the address listed below.

Initial clearance may be sent by email to: [respirator@ksu.edu](mailto:respirator@ksu.edu)  
or hard copy can be mailed to:

KSU Environmental Health & Safety  
(attn/sub: Occupational Health)  
135 Dykstra Hall  
1628 Claflin Rd.  
Manhattan, KS 66506

**or fax 785-532-1981**



**Initial Respirator Clearance and Enrollment Form**

**PART ONE** (To be completed by employee/supervisor)

**Type of respirator** (If you have questions, contact EHS by email [respirator@ksu.edu](mailto:respirator@ksu.edu), or phone 785-532-5856)

- N, R, or P disposable respirator e.g., N95, P100 (filter mask, non- cartridge type only)
- Half facepiece (negative pressure) respirator
- Full facepiece (negative pressure) respirator
- Supplied-air respirator/Airline
- Self-Contained Breathing Apparatus (SCBA)
- Powered-air purifying respirator (PAPR) **tight fit**
- Powered-air purifying respirator (PAPR) **loose fit**

**Why do you need respiratory protection?** (Check all that apply.)

- Asbestos work; check applicable:  16-hour  abatement worker  supervisor  inspector
- Laboratory worker/researcher with occupational exposure potential to specific hazards
- Facilities maintenance (e.g., painting, lead paint removal, welding, etc.) Specify: \_\_\_\_\_
- Non-routine use to permit safe entry to restricted areas where exposure is possible.
- Clinic or healthcare use  Visual or performing arts
- Hazardous waste technician\*  Emergency responder\*
- Other: \_\_\_\_\_

\*Hazardous waste and emergency response may require the use of restrictive personal protective clothing that can be confining and hot. Medical assessment for these duties should consider the burden of these special conditions. Emergency response will also involve high stress situations, and strenuous activities with physical demands beyond routine work conditions.

**Duration of respirator use**

- Escape only (no rescue)
- Emergency rescue only
- Less than 2 hours per use
- 2 to 4 hours per use
- More than 4 hours per use

**Frequency of respirator use**

- Less than 5 times per year
- 5 to 10 times per year
- About once per month
- About once per week
- Other: \_\_\_\_\_

**Expected physical work effort**

- Light/Sedentary  Moderate  Strenuous  Very Strenuous

**Potential for heat stress**

- High  Moderate  Low

If high or moderate, describe: \_\_\_\_\_

**Potential inhalation hazards or special conditions encountered while wearing the respirator(s)**

- Confined spaces  BSL3 work  Life-threatening conditions
- Chemical vapor/gas. List: \_\_\_\_\_
- Particulates. List: \_\_\_\_\_
- Radioisotopes. List: \_\_\_\_\_
- Human pathogens. List: \_\_\_\_\_
- Other: \_\_\_\_\_



### Initial Respirator Clearance and Enrollment Form

**PART TWO** (To be completed by licensed health care provider and returned directly to KSU Environmental Health & Safety by mail, email [respirator@ksu.edu](mailto:respirator@ksu.edu) or fax 785-532-1981)

#### Medical Release/Approval

I have reviewed health information and/or examined \_\_\_\_\_  
(Print KSU employee named on page 1)

and determined that they are  / are not  medically approved to wear the indicated respiratory protection devices in the performance of their job functions (as described herein [Part One]) with\*  or without  limitations.

\_\_\_\_\_  
Medical Health Care Provider Signature

\_\_\_\_\_  
Date

Name of Health Care Provider: \_\_\_\_\_

Name of Firm: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**\*If approved for one, but not all indicated respirators (refer to those checked on first page), or if approved with limitations, please provide clarification below.**

Please indicate which devices **MAY** be used by employee as applicable:

- |  |  |
|--|--|
| <input type="checkbox"/> N, R, or P disposable respirator e.g., N95, P100<br>(filter mask, non- cartridge type only) | <input type="checkbox"/> Powered-air purifying respirator (PAPR) tight fit |
| <input type="checkbox"/> Half facepiece (negative pressure) respirator   | <input type="checkbox"/> Powered-air purifying respirator (PAPR) loose fit |
| <input type="checkbox"/> Full facepiece (negative pressure) respirator   | <input type="checkbox"/> Supplied-air respirator/airline                   |
|  | <input type="checkbox"/> Self-Contained Breathing Apparatus (SCBA)         |

**If not approved for one or all of the requested devices, or if approved with limitations, indicate whether restriction is:**

- Permanent     Until further notice     Until (specify date): \_\_\_\_\_

Additional comments and/or restrictions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_