**Appendix C2: Physician’s Evaluation**

**PHYSICIAN’S or LICENSED HEALTH CARE PROFESSIONAL'S (PLHCP) EVALUATION**

|  |  |
| --- | --- |
| Employee/Student Name: |  |

**PLHCP: Please answer the following two questions:**

|  |  |  |  |
| --- | --- | --- | --- |
| Yes |  | No |  |
|  |  |  | Are there limitations on respirator use related to the medical condition of the employee, or relating to the workplace conditions in which the respirator will be used, including whether or not the employee is medically able to use the respirator? |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | Is there a need for any follow-up medical tests, consultations, or diagnostic procedures (such as a pulmonary function test) that the PLHCP deems necessary to make a final determination? |

If the PLHCP answered yes to either question above, please explain the restrictions on respirator use or the additional medical tests below:

PLHCP Name PLHCP Signature Date

At this time, I find no reason to prohibit the above-named individual from participating in programs which may require the use of respirators. I have provided the individual with a copy of my recommendation.

PLHCP Name PLHCP Signature Date