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)).