Office of Regulatory Compliance,
Environmental Health & Safety Department
1784 Racine Street, Aurora, CO 80045,
303-724-0345

University of Colorado
Denver | Anschutz Medical Campus

Initial Respirator Clearance Form

Health Clearance and Initial Enrollment to the Respiratory Protection Program

Employee Name: ____

Employee Title: ____________ Employee Signature: ____________________

Employee UCD ID#: ________________ Date: __________________________

Speedtype: ____

Employee Contact Information:

Phone: ____
Email: ____

UCD Department (or other employer):______________________________________

Employee Supervisor: ____

Phone: ____
Email: ____

Information for Employee and Supervisor

This form must be completed prior to fit testing by UCD Environmental Health and Safety (EHS). Please identify the employee above and complete only Part One of this form. After filling out Part One, send this form to the UCD EHS Medical Health Care provider (at UCD: EHS Occupational Health Fax: 303-724-9213). The fully executed form must be returned to EHS before the employee can be fit tested by UCD. If fit testing is conducted elsewhere, you must still provide documentation of fit testing and a copy of this executed form to EHS. Please note that this form must be completed in conjunction with the Respirator Medical Evaluation Questionnaire, which must also be sent to healthcare provider. **IMPORTANT:** EHS must conduct a hazard assessment or job duty review *prior to* employee enrollment into the Respiratory Protection Program and selection of respirator.

Information for Occupational Health Care Provider

The University of Colorado Denver (UCD) employee being medically evaluated will, or may be, required to wear a respirator in the execution of their work responsibilities. Following your assessment of the employee's health status (as it pertains to the use of respiratory protection devices identified herein and in accordance with the OSHA Respiratory Protection Standard 29 CFR 1910.134), please complete Part Two of this form and indicate if the person is medically cleared to wear the respiratory protection devices that have been identified/checked below and in the conditions identified herein (Part One) and by the employee and/or supervisor.

PART ONE

Type of respirator requested for use (*Contact EHS 4-0242 with questions*):

N, R, or P disposable respirator (filter mask, non-cartridge type only, such as N95)
Half face (negative pressure) respirator
Full face (negative pressure) respirator
Supplied-air respirator
Don't Know
Self-Contained Breathing Apparatus (SCBA)
Powered-air purifying respirator (PAPR) tight fit
Powered-air purifying respirator (PAPR) loose fit

During the execution of the following job activities (check all that apply):

Asbestos work (check applicable: 16-hour, abatement worker, supervisor, or inspector)
Laboratory worker/researcher with occupational exposure potential to specific hazards.
Please list:____
Facilities Maintenance (e.g., painting, lead paint removal, welding, etc.)
Please list:____
Non-routine use to permit safe entry to restricted areas where exposure is possible (e.g., restricted formaldehyde use areas, or similar condition)
Please list: ____
Clinic or healthcare use
PRF entry/work only
PRF and other needs
Visual or Performing Arts
Hazardous waste technician*
Emergency response*
Other: ____

* *Hazardous waste and emergency response operations 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, strenuous activities with physical demands beyond routine work conditions.*

Duration and frequency of respirator use:

Escape only (no rescue)
Emergency rescue only
Less than 2 hours per day
2-4 hours per day
Over 4 hours per day
Less than 5 hours per week
Other:_______________________________

If this is for field work, how many times were you in the field in the last year? ____________________
How many times do you anticipate being in the field next year? ______________________________

Expected physical work effort: Light/Sedentary Moderate Strenuous Very Strenuous

Potential for Heat Stress: High Moderate Low

If high to moderate, describe: ____

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

Confined spaces
BSL/ABSL 3 work
Life threatening conditions (e.g., IDLH)
Exposure to specific chemical vapor hazards (if known):__________________________________
Exposure to specific particulate inhalation hazard (if known):_______________________________
Inhalation of radioisotopes, list:____
Inhalation of human pathogens:____
Other:____

PART TWO

To be completed by the medical health care provider

Medical Release/Approval

I have reviewed health information and/or examined _________________________________ (*UCD employee name*) and I have determined that they are medically approved to wear the indicated Respiratory Protective Protection devices in the performance of their job functions (**as described herein [part one]**) without limitations.

______________________________ ______________________________

Medical Health Care Provider Date

Name of Health Care Provider: ____

Name of Firm: ____

Address: ____

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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***:

- N, R, or P disposable respirator, ex: N95 (filter mask, non-cartridge type only)
- Half facepiece type
- Full facepiece type
- Powered-air purifying (PAPR) tight fit
- Powered-air purifying (PAPR) loose fit
- Supplied-air respirator
- Self-contained Breathing Apparatus (SCBA)

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

Permanent Until further notice Until (specify date) ____________________

Additional comments and/or restrictions:

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