Respiratory Protection Program

RESPIRATOR APPROVAL FORM

[ ] Employee  [ ] Student

Name: ___________________________________________  Date: __/__/____

CCU ID #: ___________________________  Email: ___________________________

Position: ___________________________  Department: ___________________________

Class: ___________________________

Instructor/Supervisor: ______________________________________________________

* THIS SHADED SECTION IS TO BE FILLED OUT BY MEDICAL PERSONNEL ONLY *

Upon review of the medical questionnaire and an examination of the potential respirator wearer, the above named person is cleared for respirator fit testing and use.

Printed: ___________________________________________

Signed: ___________________________________________  Date: __/__/____

Office: ___________________________________________

Comments: ___________________________________________

________________________________________________________________________

Signature: ___________________________  Date: __/__/____

Please complete this form and return to CHO@coastal.edu.