

Respiratory Protection Processing Form

Part 1: This section should be completed by the person required by their supervisor to use respiratory protection during the course of work activities and PRIOR to the medical evaluation.

Name _____ Job Title _____
Department _____ Work Phone/NAU ID# _____

Part 2: This section should be completed by the employee's department PRIOR to the medical evaluation.

Department Supervisor _____ Date _____
Type of respirator to be used (half-face, full-face, PAPR,
etc.): _____
Description of work effort (circle one): Low Moderate Strenuous
Type of work to be performed with respirator use: _____
Special environmental conditions: _____
Names of each toxic substance during exposure/work: _____
Estimated maximum exposure level during work: _____
Duration of exposure per shift: _____

Part 3: This section should be completed by the health care provider after the medical evaluation.

Health Care Provider: NAU Campus Health Services Phone#: _____
Name of Examining Health Care Provider (print): _____
Signature of Examining Health Care Provider: _____

Patient is (circle one): without restrictions physically able to wear a respirator.
 with restrictions physically able to wear a respirator.
 Describe restrictions _____

Patient is not physically able to wear a respirator.

Part 4: This section should be completed by the employee's department AND EH&S after training and fit-testing.

Department Supervisor (print and sign): _____

Employee was was not trained in respiratory protection (circle one).
Employee was was not fit-tested with respirator (circle one).

Respirator Specifications:

Make/Model _____ Size (S/M/L) _____
Filter Type(s) _____