WRITTEN MEDICAL OPINION FOR EMPLOYER (Sample)*

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/YY MM/DD/YY

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 recommended limitations noted above: ___________ to ___________ MM/DD/YY MM/DD/YY

NEXT PERIODIC EVALUATION:
☐ 3 Years ☐ Other: ___________ MM/DD/YY

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)).

*29 CFR 1910.1053 - Respirable Crystalline Silica – Appendix B