WRITTEN MEDICAL OPINION FOR EMPLOYER

EMPLOYEE NAME: _____ **DATE OF EXAMINATION:** _____

TYPE OF EXAMINATION:

{ } Initial examination { } Periodic examination { } Specialist examination

{ } Other: _____

RESULTS OF MEDICAL EXAMINATION:

Physical Examination –	{ } Normal	{ } Abnormal (see below)	{ } Not performed
Chest X-Ray –	{ } Normal	{ } Abnormal (see below)	{ } Not performed
Breathing Test (Spirometry) –	{ } Normal	{ } Abnormal (see below)	{ } Not performed
Test for Tuberculosis –	{ } Normal	{ } Abnormal (see below)	{ } Not performed
Other: _____	{ } Normal	{ } Abnormal (see below)	{ } Not performed

Results reported as abnormal:

_____

_____

{ } Your health may be at increased risk from exposure to respirable crystalline silica due to the following:

_____

RECOMMENDATIONS:

{ } No limitations on respirator use

{ } Recommended limitations on use of respirator: _____

{ } Recommended limitations on exposure to respirable crystalline silica: _____

_____

Dates for recommended limitations, if applicable: _____ to _____
MM/DD/YYYY MM/DD/YYYY

{ } I recommend that you be examined by a Board Certified Specialist in Pulmonary Disease or Occupational Medicine

{ } Other recommendations*:

_____

_____

Your next periodic examination for silica exposure should be in: { } 3 years { } Other: _____
MM/DD/YYYY

Examining Provider: _____ Date: _____
(signature)

Provider Name: _____

Office Address: _____ Office Phone: _____

*These findings may not be related to respirable crystalline silica exposure or may not be work-related, and therefore may not be covered by the employer. These findings may necessitate follow-up and treatment by your personal physician.

Respirable Crystalline Silica standard (§ 1910.1053 or 1926.1153)