

WRITTEN MEDICAL REPORT FOR EMPLOYEE

EMPLOYEE NAME: _____

DATE OF EXAMINATION: _____

TYPE OF EXAMINATION:

☐ Initial examination ☐ Periodic examination ☐ Specialist examination
☐ Other: _____

RESULTS OF MEDICAL EXAMINATION:

Physical Examination –	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (see below)	<input type="checkbox"/> Not performed
Chest X-Ray –	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (see below)	<input type="checkbox"/> Not performed
Breathing Test (Spirometry) –	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (see below)	<input type="checkbox"/> Not performed
Test for Tuberculosis –	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (see below)	<input type="checkbox"/> Not performed
Other: _____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal (see below)	<input type="checkbox"/> 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)