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 –	[ ] 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)