

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: _____
(signature)

Date: _____

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)