Respiratory Protection Program

RESPIRATOR APPROVAL FORM

☐ Employee ☐ Student

Name: ____ Date: ____/____/______

CCU ID #: ______________________________ Email: _______________________________

Position: ________________________________ Department: __________________________

Class: __________________________________

Instructor/Supervisor: ____

* THIS SHADED SECTION IS TO BE FILLED OUT BY MEDICAL PERSONNEL ONLY *

Upon review of the medical questionnaire and an examination of the potential respirator wearer, the above named person is cleared for respirator fit testing and use.

Printed: ____

Signed: ____ Date: ____/____/______

Office: ____

Comments: ____

____

Signature: ____ Date: ____/____/______

Please complete this form and return to CHO@coastal.edu.

Department of Environmental Health and Safety | Coastal Carolina University
470 Allied Drive | P.O. Box 261954
Conway, SC 29528-6054
843-349-2770