UNIVERSITY OF SOUTH FLORIDA
REQUEST FOR MEDICAL CLEARANCE FOR RESPIRATOR USE

Name: _____ EID#: _____ Date of Birth: _____

Position (Title): _____ Supervisor: _____

Department: _____ Campus: _____

Work Phone: _____

Check Type(s) of Respirator(s) to be used:

____N, R, or P disposable respirator (filter-mask, non-cartridge type only)

____Half-mask air purifying respirator (non-powered) ____Full-facepiece air purifying respirator (non-powered)

____Other respirator, specify type: _____