



STATEMENT OF SATISFACTORY HEALTH

Name _____ Classification _____

Address _____

The above individual has been examined and found to be in good health without evidence of communicable disease and without work restrictions.

___ Has no medical condition that would be aggravated or interfere with the use of respiratory protection (N95)

___ Should not be required to wear Respiratory Protection

Physician or Nurse Practitioner:

Name _____ Phone _____
(please print)

Address _____

Signature _____ Date _____