COUNTY OF SACRAMENTO
RESPIRATORY PROTECTION CERTIFICATION

Appendix C

SECTION I - To be completed by the SUPERVISOR (Please Print)			
Employee Name:		Job Title:	
Department:	Division:		Cost Center:
Check if applicable: ☐Asbestos Team	☐Hazmat Team	☐Lead Exposure	☐Clandestine Lab
Type(s) of Respirators to be used:	☐Mandatory Use	☐Voluntary Use	
☐Half Face Air Purifying (2 lbs.)		☐Full Face Air Purifying (3 lbs.)	
☐Half Face Powered Air Purifying (5 lbs.)		☐Full Face Powered Air Purifying (7 lbs.)	
☐Hood, Powered Air Purifying (4 lbs.)		☐Hood, Airline (3 lbs.)	
☐Half Face, Airline (12 lbs.)		☐Full Face, Airline (13 lbs.)	
☐Disposable N-95/P-100 (8-10 oz.)		☐SCBA (24-32 lbs.)	
Estimated Usage Time:	☐30 or more times/year	☐15-29 times/year	☐0-14 times/year
Respirator Usage: (Check all that apply)			
☐Hazardous Waste	☐Emergency	☐Maintenance	☐Welding
☐Confined Space	☐Lab Work	☐Spray Painting	☐Pesticides
☐Chemical Handling	☐Infectious Disease	☐Other(s):	
Expected Physical Work Effort:	☐Light	☐Moderate	☐Heavy
Protective Clothing Worn:	☐Gloves	☐Boots	☐Hearing Protection
☐Chemical Handling Suit	☐Tyvek Suit	☐Rain Coat/Pants	
Temp/Humidity Extremes:	☐Indoor	☐Outdoor	
Supervisor's Printed Name:		**Phone:**	**Mail Code**:
Program Coordinator's Name:		**Phone:**	**Mail Code**:

SECTION II - To be completed by a Licensed Physician or other Licensed Health Care Professional

After reviewing the above named employee's appendix B or B1, this employee:

☐is medically qualified to wear the respirator(s) listed in SECTION I

☐is required to provide additional medical information

☐requires a follow-up medical examination

Physician's or other Licensed Health Care Professional's Printed Name: _____

Signature: _____Date: _____ ☐ County ☐ Clinic Name:_____

Date of medical examination: _____

The above named employee is:

☐medically qualified to wear the respirator(s) listed in SECTION I

☐not medically qualified for respirator use

Physician's recommendation: _____

The PLHCP has provided a copy of this certification to the employee after completing the physical.

Physician's Printed Name: _____

Signature: _____ Date: _____ Clinic Name:_____