Department of Corrections
WASHINGTON STATE

LICENSED HEALTH CARE PROVIDER INFORMATION AND RESPONSE SHEET

COMPLETED BY SUPERVISOR

Wearer name _____ DOC number _____ Position/title _____

Work location and address _____ Work phone number _____

The following respirator will be assigned to the wearer:

Type _____ Weight _____ Duration (hours and minutes) _____

Frequency of use (i.e., number of times used/day) _____ Temperature extremes _____ Humidity extremes _____

Expected physical work effort: _____

Additional personal protective equipment/clothing to be worn: _____

LICENSED HEALTH CARE PROVIDER (LHCP) INFORMATION

1. **See:**
   a. Completed DOC 03-219 Respirator Medical Evaluation Questionnaire
   b. DOC 890.090 Respirator Program available at https://doc.wa.gov/information/policies/default.aspx
   c. WAC 296-842 available at http://apps.leg.wa.gov/wac/
2. **Please:**
   a. Identify and recommend if future periodic medical evaluations are necessary below.

   b. Review the information above to consider if the user can wear a respirator as part of the user's work assignment. The wearer cannot be trained or fit tested until this form is returned signed.

   c. Provide additional medical evaluation that complies with WAC 296-842.

   d. Complete the decision section, sign, and return this form to the wearer and the wearer's supervisor OR facility Respirator Program Administrator at the following address:

Name _____ Phone number _____ Position/title _____

Address _____ Facility _____

LHCP DECISION

1. Is the wearer able to wear a respirator? ☐ Yes ☐ No
2. The wearer can wear a respirator with the following limitations (attach additional sheets as needed):
   a. _____

   b. _____
3. ☐ The wearer does not need medical re-evaluation. A medical evaluation(s) is required when a change occurs to warrant a medical re-evaluation.
   ☐ The wearer needs to complete another DOC 03-219 Respirator Medical Evaluation Questionnaire in _____ years.
   ☐ The wearer needs to be referred to another LHCP for further medical evaluation(s).

LHCP _____ Date _____

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

Distribution: **ORIGINAL** - Employee Occupational Health Record **COPY** - Wearer, Respirator Program Administrator