TEXAS TECH UNIVERSITY
Environmental Health & Safety

Occupational Health Provider Medical Evaluation Form

Completed by the Occupational Health Program provider. Do not direct to your personal physician.		
Full Name (Last, First, MI):	Phone Number:	Email:
I have reviewed the questionnaire listed above and:		
☐	Meets essential physical qualifications for the job per OHP Questionnaire. (See any comments below).	
☐	Does not meet essential physical qualifications for the job. (See comments below.)	

Physician Comments:

☐ Fit to wear N95 / half-face APR / full face APR until: _____

☐ Fit to wear other personal protective equipment (specify): _____

☐ Meets vaccination requirements for position / hazard(s).

☐ If applicable, has declined participation in vaccination or titer check.

Other Notes:

_____

_____

_____

_____

Health Care Provider Signature:	**Date:**