**WRITTEN MEDICAL OPINION FOR EMPLOYER**

**PAPERWORK REDUCTION ACT STATEMENT**

Under the respirable crystalline silica standards, it is mandatory for employers to obtain from a physician or licensed health care professional (PLHCP) or specialist a written medical opinion for each employee who meets the medical surveillance trigger, and to ensure that the employee receives a copy of the medical opinion, within 30 days of the medical examination. (29 CFR 1910.1053(i) and 29 CFR 1926.1153(h)). It is mandatory for employers to maintain the medical opinion in compliance with 29 CFR 1910.1020. (29 CFR 1910.1053(k) and 29 CFR 1926.1153(j)). Under the Paperwork Reduction Act, a Federal agency generally cannot conduct or sponsor, and the public is generally not required to respond to, an information collection, unless it is approved by OMB and displays a valid OMB Control Number. Use of this sample medical opinion is entirely optional. This sample form will assist both the PLHCP or specialist and employers to ensure that the PLHCP or specialist provides compliant employee medical documentation. OSHA estimates employer burden for the completion of this collection of information is 15 minutes. This estimates include the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The time estimate includes time for a worker to wait for the completion of forms by a PLHCP (for both the medical report for the employee and medical opinion for the employer combined) and for the PLHCP to provide the report to the worker and the opinion to the employer. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to [OSHAPRA@dol.gov](mailto:OSHAPRA@dol.gov) or to OSHA’s Directorate of Standards and Guidance, Department of Labor, Room N-3718, 200 Constitution Ave., NW, Washington, DC 20210; Attn: Paperwork Reduction Act Comment; 1218-0266. (This address is for comments regarding this form only; **DO NOT SEND ANY COMPLETED SAMPLE FORM TO THIS OFFICE**.)

OMB Approval# 1218-0266; Expires: 00-00-0000

**EMPLOYER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYEE NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF EXAMINATION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TYPE OF EXAMINATION:**

[ ] Initial examination [ ] Periodic examination [ ] Specialist examination

[ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**USE OF RESPIRATOR:**

[ ] No limitations on respirator use

[ ] Recommended limitations on use of respirator:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates for recommended limitations, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM/DD/YYYY MM/DD/YYYY

The employee has provided written authorization for disclosure of the following to the employer (if applicable):

[ ] This employee should be examined by an American Board Certified Specialist in Pulmonary Disease or Occupational Medicine

[ ] Recommended limitations on exposure to respirable crystalline silica:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates for exposure limitations noted above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM/DD/YYYY MM/DD/YYYY

**NEXT PERIODIC EVALUATION:** [ ] 3 years [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM/DD/YYYY

Examining Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

(signature)

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider’s specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] I attest that the results have been explained to the employee.

**The following is required to be checked by the** **Physician or other Licensed Health Care Professional (PLHCP)**:

[ ] I attest that this medical examination has met the requirements of the medical surveillance section of the OSHA Respirable Crystalline Silica standard (§ 1910.1053(h) or 1926.1153(h)).