RHODE ISLAND DEPARTMENT OF ENVIRONMENTAL MANAGEMENT
RESPIRATOR MEDICAL RECERTIFICATION REQUEST

Name of Employee: _____ Date: _____

Division: _____ Employee Age: _____

Site: _____ Employee ID#: _____

Job Title: _____ Home Phone No. _____

Type of Respirator Used:

_____ half face
_____ full face
_____ dust mask
_____ other _____

Specific Contaminants Encountered (pesticides, paint, etc.)

_____
_____
_____
_____
_____

Reason(s) observation(s) made for requesting a medical recertification (**be specific and detailed**).

_____
_____
_____
_____
_____

Person requesting recertification:

_____ Employee
_____ Supervisor
_____ Safety Director
_____ Other _____

Employee Signature: _____

Site Manger Signature: _____

Submit to: RIDEM – Office of Human Resources
235 Promenade Street, 3rd Floor
Providence, RI 02908

_____ Approved

_____ Not Approved

_____ Date: _____
Signature of Chief, Office of Human Resources