NCS Form 017:
Physician's Written Opinion Form
Respiratory Protection Use

EMPLOYEE_____ DATE_____

COMPANY_____ SSN _____

PHYSICIAN'S WRITTEN OPINION REGARDING EMPLOYEE WORKING WITH HAZARDOUS WASTE AND/OR HAZARDOUS SUBSTANCE AND FITNESS TO USE RESPIRATORS AND TO COMPLY WITH ANY APPLICABLE FEDERAL, STATE, AND LOCAL REGULATORY REQUIREMENTS.

1. Does the employee have any detected medical condition which would place the employee at an increased risk due to exposure to hazardous waste and/or hazardous substance incidents?
   OYes O No

2. Are there recommended limitations on the employee's exposure to hazardous waste and/or hazardous substance incidents or on the use of protective clothing and equipment such as respirators?
   O Yes O No

   List limitations _____
   _____

3. Are there medical conditions which require further examination or treatment?
   O Yes O No

4. Results of medical examination for respirator use.
   O Approved for negative Pressure respirator O Not Approved

Remarks_____

_____

Physicians Signature _____ Date _____

Physician Address: _____

Physician Phone Number: _____

The written opinion has been reviewed and explained to me and a copy provided.

Employee Signature _____ Date _____