

Morris County Public Safety Training Academy  
PO Box 900  
Morristown, New Jersey 07963-0900

**OSHA Respiratory Clearance Certification**

Recruit Name (Printed): \_\_\_\_\_

Recruit Department (Printed): \_\_\_\_\_

*To Be Completed By Healthcare Provider*

I have reviewed the **OSHA Respirator Medical Evaluation Questionnaire** provided to me by the above recruit and I have determined that he/she is medically fit to wear a Self Contained Breathing Apparatus (SCBA) while performing the duties of Firefighter Recruit, without limitations.

Healthcare Provider Name (Printed): \_\_\_\_\_

Practice / Firm: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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*Admin Use Only*

Received by Academy Date: \_\_\_\_\_