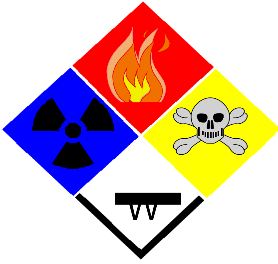
MURRAY STATE UNIVERSITY

Occupational Safety and Health Training Center



Medical Release Form

Pulmonary Function Test

PLEASE PRINT

Company/Firm/Organization: ____

Address: ____

Phone: (   )____________________ **Fax:** (   )____________________

*__Name of Individual:__ ____

Course Title: ____

Course Date(s): ____

Name of Examining Physician: ____

Address: ____

I hereby certify that ____________________________________ ***(SSN)***____________________,
(Examinee Name)
is medically fit to wear an air-purifying respirator and self-contained breathing apparatus. This training involves strenuous physical activity. I find no reason to disqualify this individual from this type of training.

Signed: ___________________________ **Date:** _____________________
(Physician)

Please return to:

Murray State University
Occupational Safety and Health Training Center
157 Industry & Technology Center
Attn: Brandon Hoehn
Murray, KY 42071-3347

Phone: (270) 809-3385
Fax: (270) 809-3630
E-mail: msu.oshtc@murraystate.edu

*** Separate forms must be completed for each individual attending training.**

This form may be reproduced.