



RESPIRATOR FIT TEST FORM

Name of Worker:		Supervisor:												
Job Title:		Dept.:		Phone:										
Does the worker wear?		Eye Glasses <input type="checkbox"/>		Dentures <input type="checkbox"/>										
				Facial Hair <input type="checkbox"/>										
Health Surveillance (a) Some conditions can affect your ability to safely use a respirator. Have you had or do you currently have any of the conditions below that may affect respirator use? Yes <input type="checkbox"/> No <input type="checkbox"/>														
Health Conditions (no need to specify): <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Chronic bronchitis</td> <td style="width: 33%;">Allergies/Sensitivities</td> <td style="width: 33%;">Other diagnosed lung disease</td> </tr> <tr> <td>Difficulty breathing</td> <td>Prescription medication</td> <td>Claustrophobia</td> </tr> <tr> <td>Asthma</td> <td>Dizziness/Nausea</td> <td>Panic attacks</td> </tr> </table>						Chronic bronchitis	Allergies/Sensitivities	Other diagnosed lung disease	Difficulty breathing	Prescription medication	Claustrophobia	Asthma	Dizziness/Nausea	Panic attacks
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Difficulty breathing	Prescription medication	Claustrophobia												
Asthma	Dizziness/Nausea	Panic attacks												
List any other conditions that you feel may interfere with respirator use: (b) Have you ever had health related difficulties while using a respirator? Yes <input type="checkbox"/> No <input type="checkbox"/>														
(c) Do you have health concerns about your ability to use a respirator safely? Yes <input type="checkbox"/> No <input type="checkbox"/> Please note: If worker answered YES to part (c) then refer to Physician Health Screening Assessment Form														
Qualitative Fit Test: <input type="checkbox"/> Quantitative Fit Test: <input type="checkbox"/>														
<input type="checkbox"/> BITREX <input type="checkbox"/> SACCHARIN Sensitivity Test Results: <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30		Difficulties testing? <input type="checkbox"/> Yes <input type="checkbox"/> No Adverse reaction to Bitrex or Saccharin? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: Sensitivity Sol. Lot # Fit Test Sol. Lot #												
Respirator(s) Fit Tested: N95 <input type="checkbox"/> Elastomeric Half-face <input type="checkbox"/> Elastomeric Full-face <input type="checkbox"/>														
Make		Model		Result										
1. _____		_____		<input type="checkbox"/> Pass <input type="checkbox"/> Fail										
2. _____		_____		<input type="checkbox"/> Pass <input type="checkbox"/> Fail										
3. _____		_____		<input type="checkbox"/> Pass <input type="checkbox"/> Fail										
Check when successfully completed: <input type="checkbox"/> Correct positioning of respirator and strap adjustments? <input type="checkbox"/> Passed seal check? <i>Remind worker to do a seal check every time they don a respirator</i>														
Information Discussed with Worker: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> When another Fit Test is required <input type="checkbox"/> Respirator limitations and reuse <input type="checkbox"/> Difference between N95 and dust mask </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Inspecting the respirator <input type="checkbox"/> Respiratory Protection Program <input type="checkbox"/> Donning & Doffing </td> </tr> </table>						<input type="checkbox"/> When another Fit Test is required <input type="checkbox"/> Respirator limitations and reuse <input type="checkbox"/> Difference between N95 and dust mask	<input type="checkbox"/> Inspecting the respirator <input type="checkbox"/> Respiratory Protection Program <input type="checkbox"/> Donning & Doffing							
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I have been fit tested and counseled in the use and limitations of the above successfully fit tested respirator. I also understand and have received an explanation of the nature, possible effects, available alternatives, and risks of the fit testing procedure.														
Employee Signature: _____ Test Date: _____														
Fit Tester Signature: _____ Next Test Date: _____														

*Please send a copy of the completed form to the OHSE Department