SAFE.FITTESTING.2.2 EMPLOYEE RESPIRATOR FIT TESTING RECORD

Employee Name: _____ Employee ID number: _____

Department Manager: _____

Work Environment	
Duration and Frequency of Use	≤ 6 hours continuous wear per day, ≤ 5 days per week
Physical effort	light ≤ 200 kcal per hour (sitting or standing while typing or performing light mechanical tasks)
Additional PPE	Lab Coat, Isolation Gown, Safety Glasses/Face Shield
Room Temperature/Humidity	18 - 25° C, 20 - 70% humidity

I have reviewed the submitted Medical Questionnaire (SAFE.FITTESTING.2.1), and taking into consideration the work environment information provided above, the associate named on this form is medically able to wear the selected respirator and submit for FIT testing.

_____ YES _____ NO Limitations related to medical or workplace conditions _____

_____

_____ A copy of this recommendation has been provided to the associate.

Signed: _____ Medical Director

Testing Media: _____

	NO	YES
Does the employee wear glasses?		
Does the employee have facial hair, dentures or other attributes that will prevent a positive face fit?		

Sensitivity Test				PASS	FAIL
Number of squeezes	**10**	**20**	**30**		
FIT Test:					
Compatible with eye glasses					
Positive pressure fit check					
Negative pressure fit check					
Head stationary, normal breathing (60 seconds)					
Head stationary, deep breathing (60 seconds)					
Head turning side to side (60 seconds)					
Head moving up and down (60 seconds)					
Talking (recite Rainbow passage or count backwards)					
Bend over (60 seconds)					
Head stationary, normal breathing (60 seconds)					
Respirator FIT test result					
Cleared for Respirator Use: _____ YES _____ No					

FIT Respirator type: Make/Model and Certificate Number: _____

FIT test completed by: _____ Date: _____

Original form kept in Department File, additional copies kept in Safety Department