|  |  |  |
| --- | --- | --- |
| **Name of the employer:** | **Site / Branch /Department / Area** | |
|  |  | |
| **Wearer’s name (PRINT PLEASE):** | | **Date of fit test:** |
| **ID number (if applicable):** | | / / |
| Are you suffering from a cold, cough, runny nose, or feeling unwell or displaying any COVID 19 symptoms within the last 24 hours? If yes, reschedule fit test. | | YES  NO |
| Have you eaten, chewed gum, smoked, vaped, or drunk anything (except water) in the last 15 minutes? If yes, delay fit test until a minimum of 15 minutes has lapsed. | | YES  NO |

Respirators can impose an extra burden on cardiac and respiratory systems and can cause physical and mental stress especially when worn for long periods and/or by those with certain health conditions. Your employer may request you be assessed by a health care professional before using a respirator in the workplace.

|  |  |  |  |
| --- | --- | --- | --- |
| **Please take a moment to look through the following list of health conditions (do not indicate any)** | | | |
| * Emphysema | | * Chronic bronchitis | * Asthma |
| * High blood pressure | | * Anxiety/panic attacks/claustrophobia | * Anemia |
| * Heart/cardiac problems | | * Shortness of breath/ breathing difficulties | * Epileptic seizures |
| * Fainting spells/seizures | | * Dizziness/fainting in hot environment | * Other condition/s that may interfere with your use of a respirator |
| * Diabetes (Insulin dependent) | | * Chest pain when climbing 4 flights of steps or less |
| Tick **one** of the following 4 options: | | | |
|  | 1. I am in good health and do not have any of the above health conditions. | | |
|  | 1. I have a well-managed health condition that does not affect my ability to wear a respirator. | | |
|  | 1. I have 1 or more of the above conditions and have medical clearance to use the selected respirator. | | |
|  | 1. I have a health condition or concerns about using a respirator (*your employer will arrange a health assessment before you can be fit tested*). | | |

**RESPIRATOR AND OTHER DETAILS**

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| --- | --- | --- |
| **Manufacturer:** | **Model:** | |
| **Style:** Disposable [ valved / non-valved ] | Half-face | **Size:** Standard S M L | |
| Wearer is appropriately shaven (less than 24-hours growth and/or no foreign material interfering with the sealing surface (eyewear temple bars/straps, dermal piercings, heavy make-up). | Yes  No | |
| Wearer inspected and independently donned respirator | Yes  No | |
| Wearer seal-check passed according to manufacturer’s instructions | **Negative** | **Positive** |
| Y  N | Y  N  NA |
| Purpose, procedures, and exercises explained to wearer | Yes  No | |
| Comfort-assessment observed (5 minutes) | Yes  NA | |

|  |  |
| --- | --- |
| Items worn or factors observed that can affect fit *(eyewear, headwear, earmuffs, jewelry, dentures, facial scars)***:** | |
| Positive pressure tight-fitting facepiece (PAPR, Supplied Air, or SCBA) converted to and fit tested in negative pressure mode (modified as per manufacturer guidance if required). | Yes  NA |

**FIT TEST DETAILS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Taste threshold sprays:** 10  20  30 | | | | Bitrex  Saccharin |
| **Taste from threshold cleared and face wiped:** YES  NO | | | | Particle filters: YES  NO |
| **Exercises (MOUTH BREATHING ONLY)** | **Duration** | | **Passed** | **Comments or corrective actions** |
| 1. Normal Breathing | 60 s | | Y N |  |
| 1. Deep Breathing | 60 s | | Y N |
| 1. Head side to side (inhaling at each side) | 60 s | | Y N |
| 1. Head up and down (inhaling while looking up) | 60 s | | Y N |
| 1. Talking (out loud) | 60 s | | Y N |
| 1. Bending over | 60 s | | Y N |
| 1. Normal Breathing | 60 s | | Y N |
| §. Taste validation passed | NA | | Y N |
| **Assumed equivalent fit factor:** ≥ 100 | | | | **PASS  FAIL** |
| Discussed with the wearer:   * Only using the make, model, and size they are fit tested for * Being appropriately shaven to achieve fit every time the tight-fitting respirator is used * Other factors that can affect fit (weight loss/gain, dentures, hair, discomfort, other PPE, damage to RPE etc.) * Frequency of fit testing (annual or earlier if any significant changes occur, such as significant weight gain or loss, trauma, scarring, dental work, swelling, surgery etc.) | | | | YES  NO |
| **Wearer’s Name:** | |  | | |
| **Fit tester name (PLEASE PRINT):** | |  | | |
| **Fit Tester Employer / Company:** | |  | | |