|  |  |
| --- | --- |
| **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 smoked or vaped in the last 30 minutes? If yes, delay fit test until a minimum of 30 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.

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| **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**

|  |  |
| --- | --- |
| **Manufacturer:** | **Model:** |
| **Style:** Disposable [ valved / non-valved ] | Half-face | Full-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 [ ]  |

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| --- |
| 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**

|  |  |
| --- | --- |
| **Pass Level:** ≥ 100 [ ]  ≥ 1000 [ ]  | **CNC serial number:**  |
| **Filters used:** <99% (P1 or P2 or N95) [ ]  >99% (P3, P100) [ ]  | **Daily checks completed:** Yes [ ]  No [ ]  |
| **Exercises** | **Passed** | **Comments or corrective actions** |
| 1. Normal Breathing
 | Yes [ ]  No [ ]  |  |
| 1. Deep Breathing
 | Yes [ ]  No [ ]  |
| 1. Head side to side (inhaling at each side)
 | Yes [ ]  No [ ]  |
| 1. Head up and down (inhaling while looking up)
 | Yes [ ]  No [ ]  |
| 1. Talking (out loud)
 | Yes [ ]  No [ ]  |
| 1. Grimace (smile / frown)
 | Excl |
| 1. Bending over
 | Yes [ ]  No [ ]  |
| 1. Normal Breathing
 | Yes [ ]  No [ ]  |
| **Overall fit factor:** |  **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:** |  |