Respirator Fit Test Intake

The information provided on this form, and the results of the screening, will not be shared with your employer

First name	Middle name	Last name	Date of birth
Phone number		Email	
Mailing Address			
Company	Position	Years in occupation	Signature

Employee to complete-Respirator mask user's health conditions (Circle YES or NO only. Do not specify).		
Some symptoms / conditions can affect your ability to safely use a respirator mask. Do you currently experience any conditions that are in an UNSTABLE STATE that may affect respirator mask use? Shortness of Breath, COPD, Emphysema, Chest pain on exertion, Hypertension, Coronary Artery Disease Angina, Dizziness, Nausea, Claustrophobia, Severe Allergic Rhinitis, Asthma Myasthenia Gravis	Yes	No
Have you had previous health concerns/difficulties while using a respirator mask?	Yes	No
Do you have concerns about your future ability to use a respirator mask safely?	Yes	No
If you selected "Yes" to any of the above, please have a healthcare professional complete a medical clearance form.		

Date:_____