Respirator User Screening Form & Fit Testing Confirmation

Date: (d/m/y): _____ **Employee Name**:_____

Employer Name: _____ A**ddress:**_____

Respirator User's Health Condition Questions

Check **Yes** or **NO** box only. **Do NOT** specify a condition or give medical information on this form.

1) Some conditions can seriously affect one's ability to safety use a respirator. Do you have or do you experience any of the following or any other condition that could affect your use of a respirator?

☐ Yes ☐ No

- ❖ Shortness of breath
- ❖ Lung disease
- ❖ Hypertension
- ❖ Neuromuscular disease
- ❖ Temperature susceptibility
- ❖ Panic attacks
- ❖ Vision impairment
- ❖ Back/Neck problems
- ❖ Breathing difficulties
- ❖ Chest pain on exertion
- ❖ Cardiovascular disease
- ❖ Fainting spells
- ❖ Claustrophobia
- ❖ Reduced sense of smell
- ❖ Unusual facial features/Skin conditions
- ❖ Chronic bronchitis
- ❖ Heart problems
- ❖ Thyroid problems
- ❖ Dizziness/Nausea
- ❖ Asthma
- ❖ Reduced sense of taste
- ❖ Emphysema
- ❖ Allergies
- ❖ Diabetes
- ❖ Seizures
- ❖ Pacemaker

2) Have you had previous difficulty while using a respirator? ☐ **Yes** ☐ **No**

3) Do you have any concerns about your future ability to use a respirator safety? ☐ **Yes** ☐ **No**

If you answered "**Yes**" to any of the three questions above, further assessment by a health care professional is required prior to respirator use.

_____ _____

Signature of Respirator User Signature of Fit Tester

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Conditions of Use

Title / Occupation of User: _____

Activities Requiring Respirator Use:_____

Frequency of Respirator Use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

☐ Other: _____

Exertion During Use: ☐ Light ☐ Moderate ☐ Heavy

☐ Other: _____

Duration of use per shift: ☐ less than 15 mins ☐ more than 15 mins ☐ more than 2 hours

☐ All shift ☐ other:_____

Temperature during use:

☐ Less than 0º C
☐ Less than 25º C
☐ More than 25º C
☐ Other: _____

Special Work Conditions:

☐ Normal Work Procedure
☐ Fire Fighting
☐ Rescue
☐ Spill control
☐ Confined Space Entry
☐ Emergency Escape

☐ Oxygen Deficiency/Enrichment
☐ IDLH
☐ Other: _____

What other PPE is required to be worn?

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Estimated total weight of tools/equipment/clothing during use:

Minimum _____ / Maximum _____ (kg / lb.) – please circle units of measure

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Fit Test Attempt #: _____ **Date of most recent Fit Test: (d/m/y)** _____

Date of Last Theory Training: _____ (day / month / year)

Respirator Manufacturer: _____

Respirator Model #: _____ Size: _____

Full Face _____ Half Mask _____ Fiber Filter (dust mask) _____

Test Fit for Comfort Evaluation

Note: Circle one answer

User Competency: YES NO **PPE Compatibility:** YES NO

Comfort Assessment Score: (after 5 mins.) **Comfort Score:** _____

0 = No issues
1 = Discomfort that can be ignored
2 = Some discomfort but still able to function [initiate re-donning / repositioning or use alternate]
3 = UNACCEPTABLE discomfort–not bearable [reject respirator; find alternative or protective alternate]

Sensitivity Test Number:	x10	x20	x30
Sensitivity Solution Used:	Bitter ☐	Saccharin ☐	

Test Results: PASS w/non-detection FAIL w/detection

Acceptable Comfort Question: Does this specific respirator provide you an acceptable comfort level for the scope of your work?

YES **NO**

Fit Tester: _____ _____
(Print) (Signature)

Date of Next Fit Test: no later than (d/m/y) _____ / _____ / _____

Note: Employer must retain this form as a record of this procedure. Fit testing must be completed every 2 years regardless of the frequency of use by the wearer, including situations where the use of a respirator is voluntary or provided to accommodate an individual.