Individual Respirator Fit Test Record

Employee Name: _____ Date: _____

Employer: _____ Job Title: _____

Address: _____ County: _____

Respirator Type Selected: _____ Manufacturer: _____

Model: _____ Size: _____ Medically Cleared: YES NO

Medical Clearance Provided by: Health Care Provider: Name_____

Date: _____

On-line Provider: Name_____ AgriSafe RN: _____

Date: _____ Date: _____

CONDITIONS WHICH COULD AFFECT FESPIRATOR FIT:

Clean Shaven ____ Facial Hair ____ Glasses ____ Facial Scar ____

Dentures absent ____ Teeth Missing ____ Other ____

COMMENTS: _____

FIT TESTING:

Qualitative: BITREX (# of Squeezes ____ sensitivity)

(# of Squeezes ____ fit test) PASS ____ FAIL ____

FIT CHECKS:

Negative Pressure PASS ____ FAIL ____

Positive Pressure PASS ____ FAIL ____

EMPLOYEE ACKNOWLEDGEMENT of RESULTS:

Employee Signature: _____

Test Conducted By: _____

Date: _____

Respirator Fit Test Card

Name: _____

Test Date: _____ Next Test: _____

Respirator Make/Model: _____

Protocol: 29 CFR 1910.134

Pass or Fail: _____