



Life. Well Crafted.

**SAFETY STANDARD OPERATING PROCEDURES**

**Respiratory Mask Fit Test Form**  
**Risk Division**

**Effective Date: February 8, 2018**  
**Revision (01)**

Employee: \_\_\_\_\_

Last four (4) SS# \_\_\_\_\_

Job Function: \_\_\_\_\_

Location: \_\_\_\_\_

Type of Respirator: \_\_\_\_\_

Type of Cartridge/Filter : \_\_\_\_\_

Fit Test Protocol: \_\_\_\_\_

NIOSH# \_\_\_\_\_

Manufacturer: \_\_\_\_\_

Model: \_\_\_\_\_

Size: \_\_\_\_\_

**Prerequisites to Fit Test**

- |   |     |    |     |
|---|-----|----|-----|
| 1. Has the required medical screening been completed?   | Yes | No | N/A |
| 2. Does the Physical Examination Request form indicate that employee is qualified to wear respirator? | Yes | No | N/A |
| 3. Has the Respirator Medical Evaluation Questionnaire been completed and provided to the physician?  | Yes | No | N/A |

**Characteristics for Seal**

- |   |     |    |     |
|---|-----|----|-----|
| 1. Clean Shaven?  | Yes | No | N/A |
| 2. Facial hair does not interfere with respirator seal? | Yes | No | N/A |
| 3. Facial scars do not interfere with respirator seal?  | Yes | No | N/A |
| 4. Contact lenses are not being worn?                   | Yes | No | N/A |
| 5. Eye glasses do not interfere with respirator seal?   | Yes | No | N/A |
| 6. Dentures in place?                                   | Yes | No | N/A |

**Employee Acknowledgement**

Employee acknowledges the following requirements:

- |   |     |    |     |
|---|-----|----|-----|
| 1. Perform a positive/negative fit test each time respirator is donned.                                       | Yes | No | N/A |
| 2. Discontinue use of modified, altered or damaged respirators.   | Yes | No | N/A |
| 3. Assure facial hair, eyeglasses or clothing does not interfere with respirator seal each time it is donned. | Yes | No | N/A |

**Note: A new fit test must be performed in the event of significant weight gain/loss (20 lb.), dental work or any facial change that may affect the seal of the respirator.**

Employee **PASSED** respiratory fit test  
Employee Signature: \_\_\_\_\_

Employee **FAILED** respiratory fit test  
Date: \_\_/\_\_/20\_\_

Conductors Signature \_\_\_\_\_

Date: \_\_/\_\_/20\_\_

**Note: Please return a completed copy to Risk Management**