APPENDIX O: Place LHD Logo Here

**Respirator Fit Test Record**

**Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials:** \_\_\_\_\_

**Type of qualitative fit test solution used (circle): Saccharin or Bitrex**

**Test Operator Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials:** \_\_\_\_\_

**Date: \_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Respirator Mfr./Model/Approval no.*** | ***Size*** | ***Pass/Fail*** |  |
|  | | | |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | S M L | P F |  |
| 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | S M L | P F |  |
| 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | S M L | P F |  |
| 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | S M L | P F |  |

**Medical Screening Questionnaire Completed? Yes \_\_\_\_ No \_\_\_\_ If no, why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical referral required? Yes \_\_\_\_ No \_\_\_\_**

**Medical Evaluation completion date: \_\_\_\_\_\_\_\_\_\_**

**Is Employee Able to be Fit Tested: Yes \_\_\_\_\_ No \_\_\_\_\_\_\_**

NOTES:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This record indicates that you have passed or failed a qualitative fit test as shown above for the particular respirator(s) shown. Other types will not be used until fit tested.

**PHPS-R004**

**7/1/2025**