



Respirator Fit Test Record

Employee Name: _____

Field Station: _____

Supervisor Name: _____

A respirator fit test must be completed by an individual trained in respiratory fit testing procedures. **This fit test is required annually.**

Qualitative Fit Test ____ Quantitative Fit Test ____

Does employee wear glasses? ____ Yes ____ No

Does Employee have facial hair, dentures or other attributes that may prevent a positive face fit?
____ Yes ____ No

Testing media: _____ TSI Port Account Pro+ Calibration Date: _____

Respirator Type (Make and Model): _____

Medical Clearance Completed (FWS Form 3-2364)? ____ Yes ____ No

Compatible with eye glasses? ____ Yes ____ No
Positive pressure fit check? ____ Pass ____ Fail
Negative pressure fit check? ____ Pass ____ Fail

	Qualitative Fit Test	Quantitative Fit Test
Head Stationary Normal Breathing (60 seconds)?	____ Pass ____ Fail	____ Fit Factor
Head Stationary Deep Breathing (60 seconds)?	____ Pass ____ Fail	____ Fit Factor
Head Turning Side To Side (60 seconds)?	____ Pass ____ Fail	____ Fit Factor
Head Moving Up and Down (60 seconds)?	____ Pass ____ Fail	____ Fit Factor
Talking (recite Rainbow Passage or count backwards)?	____ Pass ____ Fail	____ Fit Factor
Bending Over (60 seconds)?	____ Pass ____ Fail	____ Fit Factor
Head Stationary Normal Breathing (60 seconds)?	____ Pass ____ Fail	____ Fit Factor
Respirator fit test result?	____ Pass ____ Fail	____ Fit Factor (Total)

Based on information provided on this form, I certify that the employee named on this form can wear the respiratory protective equipment listed above.

Signature of Person Administering Test

Date