



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.**

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: _____

Respirator Type (Make Model and Certification Number): _____

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

Head Stationary Normal
Breathing (60 seconds)? Pass Fail

Head Stationary Deep
Breathing (60 seconds)? Pass Fail

Head Turning Side To Side
(60 seconds)? Pass Fail

Head Moving Up and Down
(60 seconds)? Pass Fail

Talking (recite Rainbow
Passage or count backwards)? Pass Fail

Bending Over (60 seconds)? Pass Fail

Head Stationary Normal
Breathing (60 seconds)? Pass Fail

Respirator fit test result? Pass Fail

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