



# Fit Test Form / Respirator User Screen Form

Please select your training location:

**SUDBURY** 1545 Maley Drive  
Sudbury ON, P3A 4R7

**TIMMINS** 76 McIntyre Road  
Schumacher ON, P0N 1G0

**A completed copy of this form MUST BE RETURNED TO YOUR EMPLOYER.**

*For initial and periodic screening of respirator users in conjunction with CSA Z94.4, Clause12*

## PART 1: EMPLOYER INFORMATION

Employer name: \_\_\_\_\_

Supervisor name: \_\_\_\_\_

Telephone: ( ) –Fax: ( ) or E-mail \_\_\_\_\_

## PART 2: RESPIRATOR USER INFORMATION

Name: \_\_\_\_\_

Title/Occupation: \_\_\_\_\_

Telephone: ( ) – Fax: ( ) or E-mail \_\_\_\_\_

## PART 3: CONDITIONS OF USE

**ACTIVITIES** requiring respirator use: \_\_\_\_\_

**FREQUENCY** of respirator use: (circle one)

Daily

Weekly

Monthly

Yearly

Other

**EXERTION** level during use: (circle one)

Light

Moderate

Heavy

Other

**DURATION** of respirator use per shift: (circle one)

<1/4 h

>1/4 h

>2 h

Variable

Other

Other personal protective equipment (specify): \_\_\_\_\_

## Respirator User’s Health Conditions

Circle **YES** or **NO** only. **DO NOT** specify note: **Medical information is NOT to be offered on this form.**

- a) Some conditions can seriously affect your ability to safely use a respirator.  
Do you have or do you experience any of the following or any other condition that could affect respirator use?

**YES** or **NO**

Allergies | Asthma | Back/Neck problems | Breathing difficulties | Cardiovascular disease | Chest pain of exertion  
Chronic Bronchitis | Claustrophobia | Colour blindness | Dentures | Diabetes | Dizziness/Nausea | Emphysema  
Fainting spells | Fear of heights | Hearing impairment | Heart problems | Hypertension | Lung disease  
Neuromuscular disease | Pacemaker | Panic attacks | Prescription medication to control a condition  
Reduced sense of smell | Seizures | Shortness of breath | Temperature susceptibility | Thyroid problems  
Unusual facial features/Skin conditions | Vision impairment | Other condition(s) affecting respirator use

- b) Have you had previous difficulty while using a respirator?

**YES** or **NO**

- c) Do you have any concerns about your future ability to use a respirator safely?  
A “YES” answer to (a), (b), or (c) indicates further assessment by a health care professional is required prior to respirator use.

**YES** or **NO**

## TYPES OF RESPIRATOR USED/REQUESTED: (PLEASE CHECK)

Fit:  Half mask

Full face

Brand:  3M

NORTH

MSA

Signature of respirator user: \_\_\_\_\_

Signature of Supervisor: \_\_\_\_\_

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

**NOTE: Client MUST be CLEAN SHAVEN in order to be tested.**