Carleton University

Office of Risk Management
Environmental Health & Safety

RESPIRATORY FIT TEST MEDICAL SCREENING FORM

Respirator user must complete parts 1 - 3

PART 1: RESPIRATOR USER INFORMATION

First Name: _____ **Last Name:** _____

ID Number: _____ **Telephone:** _____

Department: _____ **Job Title:** _____

Supervisor Name: _____

PART 2: CONDITIONS OF USE AND SPECIAL WORK CONSIDERATIONS

Activities requiring respirator use: _____

Frequency of respirator use: ☐ daily ☐ weekly ☐ monthly ☐ yearly ☐ uncertain

Exertion level during use: ☐ light ☐ moderate ☐ heavy ☐ other

Duration of respirator use per shift: ☐ < ¼ hour ☐ > ¼ hour ☐ > 2 hours ☐ variable

Other personal protective equipment (PPE):

☐ Not applicable

☐ Additional types of PPE equipment will be worn during respirator use:

Please specify: _____

PART 3: RESPIRATOR USER HEALTH CONDITIONS

(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? Check YES or NO. DO NOT specify the condition(s).

Shortness of breath	Breathing difficulties	Heart problems	Yes ☐ No ☐
Lung disease	Chest pain or exertion	Dizziness/nausea	
Hypertension	Cardiovascular disease	Emphysema Seizures	
Neuromuscular disease	Fainting spells	Asthma	
Pacemaker	Claustrophobia	Back/neck problems	
Facial features/skin conditions	Panic attacks	Chronic bronchitis	

(b) Have you had previous difficulty while using a respirator? Yes ☐ No ☐

(c) Do you have concerns about your future ability to use a respirator safely? Yes ☐ No ☐

Please note: if you answered Yes to (a), (b), or (c), further assessment by health care professional is required prior to respirator use.

Signature: _____ **Date:** _____

Please note: EHS conducts fit-testing with a limited number of respirator options. If a department uses a specific make and model of respirator, the user is responsible for bringing a respirator to the fit-testing session. Please contact EHS if you have any questions.

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PART 4: HEALTH CARE PROFESSIONAL ASSESSMENT

☐ **Medically cleared for respirator use - no restrictions**

☐ **Medically cleared for respirator use - some specific restriction (explain):**

☐ **No respirator use permitted (explain):**

Name of the health care professional:

Signature : _____ **Date:** _____