SASKATCHEWAN ASSOCIATION FOR
SAFE WORKPLACES
IN HEALTH

Respirator Fit Test User Screening Form

PART 1: RESPIRATOR USER INFORMATION

Name: ____________________ Employee #: ____________________
Email: ____________________ Title/occupation: ____________________
Phone #: ____________________ Fax # ____________________

PART 2: EMPLOYER INFORMATION

Employer name: ____________________
Date: ____________________ Worksite address: ____________________
Supervisor name: ____________________ Supervisor email: ____________________
Supervisor ph: ____________________ Supervisor fax: ____________________

PART 3: CONDITIONS OF USE

Activities requiring respirator use: ____________________

Frequency of respirator use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other

Exertion level during use: ☐ Light ☐ Moderate ☐ Heavy ☐ Other

Duration of respirator use per shift ☐ <1/4 h ☐ >1/4 h ☐ >2 h ☐ Variable ☐ Other

Temperature during use: ☐ <0° C ☐ >0 and <25°C ☐ >25°C

Atmospheric pressure during use: ☐ Reduced ☐ Normal/ambient ☐ Increased

SPECIAL WORK CONSIDERATIONS

Uncontrolled hostile environment: ____________________

☐ Atmospheres immediately dangerous to life ☐ Firefighting ☐ Riot/police activity ☐ Rescue operations

☐ Hazardous materials (emergency) ☐ Oxygen deficiency ☐ Confined spaces

☐ Other: ____________________

Other personal protective equipment (PPE):

☐ Additional types of PPE required: ☐ goggles ☐ face shield ☐ bonnet

☐ other (specify) ____________________

☐ Estimated total weight of tools/equipment carried during respirator use: Maximum: ____ Average: ____

PART 4: TYPES OF RESPIRATORS USED (check all that apply)

☐ Tight-fitting ☐ Non-tight-fitting (e.g., hood) ☐ SCBA - open circuit ☐ Mouth bit

☐ SCBA - closed-circuit ☐ Air-purifying, non-powered ☐ Airline, continuous-flow ☐ SCA - escape

☐ Air-purifying, powered ☐ Airline, pressure-demand ☐ SCBA - closed-circuit escape

☐ Multi-functional pressure-demand/Airline with escape ☐ Supplied-air suit

☐ Combined airline with air-purifying elements ☐ Other (specify): ____________________

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PART 5: RESPIRATOR USER'S HEALTH CONDITIONS

Medical information is **NOT** to be offered on this form.

Check just the Yes or No box only - DO NOT SPECIFY.
1. Some conditions can seriously affect your ability to safely use a respirator. Do you have or do you experience any of the following, or another condition **that may affect respirator use**? Yes ☐ No ☐

- shortness of breath
- breathing difficulties
- chronic bronchitis
- emphysema
- lung disease
- chest pain on exertion
- heart problems
- allergies
- hypertension
- cardiovascular disease
- thyroid problems
- diabetes
- neuromuscular disease
- fainting spells
- dizziness/nausea
- seizures
- temperature susceptibility
- claustrophobia/fear of heights
- hearing impairment
- dentures
- panic attacks
- color blindness
- asthma
- pacemaker
- vision impairment
- reduced sense of smell
- reduced sense of taste
- back/neck problems
- unusual facial features/skin conditions
- prescription medication to control a condition
- other conditions affecting respirator use

2. Have you experienced allergies or adverse health reactions to any of the following? Yes ☐ No ☐
household chemicals, latex, dental anesthetic, artificial sweeteners

3. Have you had previous difficulty while using a respirator? Yes ☐ No ☐

4. Do you have any concerns about your future ability to use a respirator safely? Yes ☐ No ☐

5. Have you ever had a severe adverse health reaction or condition while undergoing a fit testing process? Yes ☐ No ☐

A "**YES**" answer to question 1, 2, 3, 4 or 5 indicates further assessment by a health care professional is **required** prior to respirator use.

Signature of respirator user: ______________________ Date: __________ Supervisor's initials: ______

PART 6: HEALTH CARE PROFESSIONAL PRIMARY ASSESSMENT (if required)

Health care professional is defined as an individual who is licensed by a provincial licensing authority or equivalent to practice medicine or nursing and who possesses experience and knowledge in the field of occupational health and safety. The degree of knowledge/experience required by the health care professional is to be sufficient to understand why the respirator is being worn during the course of the work and that in doing so the individual in question is not at risk.

Assessment date: ________________________________

Respirator use permitted ☐ Yes ☐ No ☐ Uncertain

Referred to medical assessment ☐ Yes ☐ No

Comments: ____

Reassessment date: ______________ Name of healthcare professional (HCP): ________________________

Title of HCP: ______________________________ Signature of HCP: ______________________________

PART 7: MEDICAL ASSESSMENT (if required) **DO NOT** include specific personal health information.

Class 1. No restrictions
Class 2. Some specific restrictions apply (specify): ____
Class 2. Some specific restrictions apply (specify) ____
Class 3. respirator use is NOT permitted.

Name of physician: ______________________ Signature of physician: __________________________

Participants must take this completed screening form to the Respiratory Fit Testing training.
SASWH recommends the employer retain a copy for their records

source: CSA Standard Z94.4-18: *Selection, use, and care of respirators* (Sept 2018)