



FOB - Respirator Fit Test Record

Function of Beauty Location: _____ Address: _____ Date: __/__/__
 Employee Name: _____ Department: _____
 Supervisor Name: _____ EHS Representative: _____

Type of OSHA accepted fit test protocol used:

Qualitative Fit Test: ___ Saccharin ___ Bitrex ___ Isoamyl Acetate ___ Irritant Smoke
 Fit Test Kit Brand and Model: _____ Individual Sensitivity: _____ (10/20/30)

Quantitative: Portacount Model # _____ OH Dynamic Model # _____

Respirator Type (Make and Model): _____

Medical Clearance Completed? ___ Yes ___ No

Respirator Compatible with eyeglasses? ___ Yes ___ No

Positive Pressure fit check? ___ Pass ___ Fail

Negative Pressure fit check? ___ Pass ___ Fail

	Qualitative Fit Test Action	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
Respirator Fit Test Result?	___ Pass ___ Fail	___ Fit Factor (Total)

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

Name of Fit Tester: _____ Signature: _____ Date: __/__/__