

STATE OF NEW YORK – DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION
N-95 DISPOSABLE FILTER RESPIRATOR (DUST MASK TYPE ONLY) FIT TEST RECORD

A. Employee _____ Date _____
Employee Job Title/Description _____

B. Respirator Selected _____
Manufacturer _____
NIOSH Approval Number _____
Model _____ Style/Size _____

C. Conditions Which Could Affect Respirator Fit: (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Clean Shaven | <input type="checkbox"/> Facial Scar |
| <input type="checkbox"/> Beard Growth | <input type="checkbox"/> Dentures Absent |
| <input type="checkbox"/> Mustache | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> None |

*If any of the above conditions interfere with the function or seal of the respirator, fit testing is not permitted unless the condition is corrected.

Comments: _____

D. Fit Testing (check all methods used)

Qualitative Fit Testing

- | | | |
|-----------------|-------------------------------|-------------------------------|
| Bitrex | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail |
| Isoamyl Acetate | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail |
| Saccharin Test | <input type="checkbox"/> Pass | <input type="checkbox"/> Fail |

Comments: _____

Test Conducted By: _____ Date: _____