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# **CERTIFICATE OF EXAM---RESPIRATOR FIT TEST**

Patient:					
Date of Birth:					
Banner:					
Department:					
Respirator Manufacture	er:				
Model:	N95 Particulate R	espirator	Pro Gear		
NIOSH approval #	RP88020	RP88010			
Size:	Regular	Small			
Testing Method:	Qualitative-Bitter	Sweet			
This p	atient <b>FAILED</b> the respirator p	hysical / fit testing proc	edure.		
This patient is <b>NOT</b> clea	red to wear respirator protect	ion.			
Examiner's signature an	nd Date				
Patient's signature and	Date				
This	patient <b>PASSED</b> the respirator	physical / fit testing pro	ocedure.		
The patient may wear re	espirator specified above.				
Acl	knowledgement of Understan	nding of User Instruction	ns and Limitations.		
respirator. I will follow the	,, ·	he respirator. I understand	est procedure and the limitations of the d this certification expires one year from e respirator past that date.		
If any of the f	following occur, I will notify the S	tudent Health office so th	nat fit testing may be repeated:		
Weight change of 20 or more	pounds	Signific	Significant facial scarring		
Facial surgery		Dental	ental changes		
Facial hair growth		Throat,	oat/nose irritation when I am wearing the respirator		
Odor of contaminants occurs	when I am wearing the respirator				
Examiner's signature and Date	e				
Patient's signature and Date					

## **USER INSTRUCTIONS**

OSHA requires fit testing for all employees who wear respirators. To ensure that PFR95 Particulate Filter Respirators provide the intended level of protection, every wearer should receive training. This includes demonstrations and practice time on how to properly don the respirator and to determine if it fits correctly.

### **Directions for Proper Donning 3M 1860-1860S Respirator**

Proper donning of a PFR95 Particulate Filter Respirator may feel a little awkward at first, but it will become easier with repeated applications. The following instructions should be followed when donning this product:

- 1. Cup the respirator in your hand with the nosepiece at fingertips, allowing the head straps to hang freely below hand.
- 2. Position the respirator under your chin with the nosepiece up.
- 3. While holding the respirator in place, pull the top strap over your head so it rests high on the back of your head.
- 4. While continuing to hold the respirator firmly in place, pull the bottom strap over your head and position it around your neck, below your ears. Untwist the straps. Position the respirator low on your nose.
- 5. Using both hands, mold the nosepiece to the shape of your nose by pushing inward while moving your fingertips down both sides of the nosepiece. (Note: Always use two hands when molding nosepiece. Pinching with one hand may result in improper fit and less effective respirator performance.)
- 6. Now, perform a positive pressure Fit Check.

## **Directions for Fit Checking:**

To ensure PFR95 Particulate Filter Respirators are providing the intended level of protection, they MUST be "Fit Checked" each and every time they are worn.

To perform the fit check, place both hands completely over the respirator, being careful not to disturb the position, and exhale sharply. If air leaks around your nose, adjust the nosepiece as described in step 5. If air leaks at respirator edges, adjust the straps back along the sides of your head. Perform fit check again if an adjustment is made. If you cannot achieve a proper fit, see your supervisor. Do not enter area requiring use.

Note: Fit Checking is NOT a substitute for Fit Testing. Fit Checking is a simple procedure intended to help the wearer verify that he/she has properly donned the respirator. Fit testing is designed to determine the appropriate size respirator for each wearer. Fit Testing should be conducted as determined in your facility's respiratory protection program.

# Tips for Achieving a Good Fit

If the wearer is having a problem successfully Fit Checking the respirator, he/she should try the following tips:

- 1. Use a mirror while adjusting the respirator.
- 2. Ask someone to look for the hair or earrings that might be caught in the seal.

#### **SAFETY REMINDER**

The respirator must be Fit Checked each and every time it is donned.

Do Not proceed with activities until a successful Fit Check has been completed.

# **OSHA Respirator Medical Evaluation Questionnaire**

Patient:					
Date of Birth:					
Banner:					
Department:					
Date	Age:	Sex (circle one):	Male	Female	
examination. However and provide a medical	r, it does require that evaluation to deterr		Health Ca ity to use	re Professional (PL	not require a medical HCP) review this questionnair the employee is fit tested or
To the employee:					
Can you read? (Circle	one) Yes/No				
convenient to you. To	maintain your confid		or superv	visor must not look	a time and place that is at or review your answers, an sional who will review it.
Part A. Section 1. (Ma	ndatory)				
The following information	tion must be provide	ed by every worker who h	nas been s	selected to use any	type of respirator (please prir
1. Height:ft	in. We	eightlbs.			
2. A phone number wh	nere you can be reac	hed by the healthcare pr	ofessiona	I who reviews this (	questionnaire (include the Are
3. The best time to pho	one you at this numb	per:			
4. Yes No Ha	as your employer tolo	d you how to contact the	health ca	re professional wh	o will review this questionnain
5. Check the type of re	espirator you will use	(you can check more tha	an one ca	tegory):	
a <u>. N</u> N, R, or	P disposable respira	tor (filter-mask, non-cart	ridge type	e only).	
b Other typaparatus).	pe (for example, half	or full-face-piece type, p	oowered-a	air purifying, suppli	ed air, self-contained breathir
6. Yes No Have yo	ou worn a respirator?	?			
I	f "yes", what type (s	):			?
Part A. Section 2. (Ma use any type of respira	• •	-	oe answei	red by every emplo	yee who has been selected to
1. Yes No Do you co	urrently smoke tobac	cco, or have you smoked	tobacco i	n the last month	
2. Have you ever had a	any of the following o	conditions?			
Yes No a. Seizures ( breathing	(fits) Yes No b.	Diabetes (sugar disease)	Yes No	o c. Allergic reacti	ions that interfere with your
Ves No d Claustron	nhohia (fear of close)	d-in nlaces)		'Yes No e Tro	nuble smelling adors

- 3. Have you ever had any of the following pulmonary or lung problems?
- Yes No a. Asbestosis Yes No b. Asthma Yes No c. Chronic bronchitis

Yes No d. Emphysema

Yes No e. Pneumonia Yes No f. Tuberculosis Yes No g. Silicosis Yes No h.

Pneumothorax

- Yes No I. Lung cancer Yes No j. Broken ribs Yes No k. Any chest injuries or surgeries
- Yes No I. Any other lung problem that you've been told about

#### OSHA Respiratory Medical Evaluation Questionnaire---continued-page 2

- 4. Do you currently have any of the following symptoms of pulmonary or lung illness?
- Yes No a. Shortness of breath
- Yes No b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
- Yes No c. Shortness of breath when walking with other people at an ordinary pace on level ground
- Yes No d. Have to stop for breath when walking at your own pace on level ground
- Yes No e. Shortness of breath when washing or dressing yourself
- Yes No f. Shortness of breath that interferes with your job
- Yes No g. Coughing that produces phlegm (thick sputum)
- Yes No h. Coughing that wakes you early in the morning
- Yes No i. Coughing that occurs mostly when you are lying down
- Yes No j. Coughing up blood in the past month
- Yes No k. Wheezing
- Yes No I. Wheezing that interferes with your job
- Yes No m. Chest pain when you breathe deeply
- Yes No n. Any other symptoms that you think may be related to lung problems
- 5. Have you ever had any of the following cardiovascular or heart problems?
- Yes No a. Heart attack
- Yes No b. Stroke
- Yes No c. Angina
- Yes No d. Heart failure
- Yes No e. Swelling in your legs or feet (not caused by walking)
- Yes No f. Heart arrhythmia (heart beating irregularly)
- Yes No g. High blood pressure
- Yes No h. Any other heart problem that you've been told about

6. Have you ever had any of the following cardiovascular or heart symptoms? Yes No a. Frequent pain or tightness in your chest? Yes No b. Pain or tightness in your chest during physical activity Yes No c. Pain or tightness in your chest that interferes with your job Yes No d. In the past two years, have you noticed your heart skipping or missing a beat? Yes No e. Heartburn or indigestion that is not related to eating Yes No f. Any other symptoms that you think may be related to heart or circulation problems 7. Do you currently take medication for any of the following problems? Yes No a. Breathing or lung problems Yes No b. Heart trouble Yes No c. Blood pressure Yes No d. Seizures (fits) 8. If you have used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check the following space\_\_\_\_\_ and go to question 9). Yes No a. Eye irritation Yes No b. Skin allergies or rashes Yes No c. Anxiety Yes No d. General weakness or fatigue

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this

Yes No e. Any other problem that interferes with your use of a respirator

questionnaire?

Yes No