



HOWARD COUNTY
GENERAL HOSPITAL

JOHNS HOPKINS MEDICINE

OCCUPATIONAL HEALTH

RESPIRATORY FIT AND TRAINING VERIFICATION

PLEASE PRINT:

Name: _____ SS#: XXX-XX-_____

Department: _____ DOB: _____

PLEASE STOP HERE. THE OCCUPATIONAL HEALTH NURSE WILL COMPLETE THE REST OF THIS FORM.

Screened by: Occupational Health Other

Description of Respirator:

Brand and Model: *Technol N-95*

NIOSH Approval: N-95 NIOSH Approval

Limitations: Beard Dentures Glasses None

Size: Small Regular

Comments or other findings: _____

Fitting: Face Fit Check Sweetener

Assessment of Worker's Ability to Use N-95 Mask: Able Not able

Brand and Model: *Airmate HEPA PAPR*

Assessment of Worker's Ability to Wear: Able Not able

Comments: _____

Additional Comments or Recommendations: _____

Date: _____

Employee's Signature: _____

Date: _____

Evaluated By: _____