HOWARD COUNTY GENERAL HOSPITAL

JOHNS HOPKINS MEDICINE

OCCUPATIONAL HEALTH
RESPIRATORY FIT AND TRAINING VERIFICATION

PLEASE PRINT:

Name: ____ SS#: XXX-XX-____________________

Department: ____________________________________ DOB: ______________________

Date: ____________________ Employee's Signature: ____________________________

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

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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 ☐

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Brand and Model: ***Airmate HEPA PAPR***

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

Comments: ____

Additional Comments or
Recommendations:____

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Date: ____________________ Evaluated By: ____________________________________

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3/2019