

Qualitative Fit Test Report

Employee Name:		
Department:		
Hospital:		
Date of Test:		
Is the person clean shaven?	Yes	No
Is the person medically fit?	Yes	No
Is the person nil by mouth in the last 15 mins?	Yes	No
Has the person smoked/vaped in the last 15 mins?	Yes	No

SENSITIVITY TEST: Please circle the sensitivity level, based on the outcome of your sensitivity test.

No. of sensitivity sprays	First dose for fit test	Top up dose for fit test
1-10	10	5
11-20	20	10
21-30	30	15

Please identify what was used in your fit test:

Respirator type (please circle):	Cone Valved FSM09	Duckbill Valved FSM14
	Cone Unvalved FSM15	Duckbill Unvalved FSM16
Other facial PPE worn ie: visor/glasses/hearing aids:		
Make:	Model:	

Test conducted using:	Sweet test solution	Bitter test solution
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FIT TEST EXERCISES:	Pass	Fail
Normal breathing		
Deep breathing		
Turning head side to side		
Moving head up and down		
Talking out loud - Rainbow Passage		
Bending over		
Normal breathing		

Test result:	Passed 1st time	Passed 2nd time	Failed
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Tested by (print): _____

Signature: _____